

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION

Advisory Committee to the Director (ACD) of CDC



Summary Report

**October 28, 2010
Atlanta, Georgia**

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Acronyms

Acronym	Expansion
ACD	Advisory Committee to the Director
ACIP	Advisory Committee for Immunization Practices
ACO	Accountable Care Organizations
AIDS	Acquired Immune Deficiency Syndrome
API	Asian and Pacific Islander
BCU	Biosurveillance Coordination Unit
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
BSC	Board of Scientific Counselors
CBO	County Board of Supervisors
CDC	Centers for Disease Control and Prevention
CGH	Centers for Global Health
CMS	Centers for Medicare and Medicaid Services
DFO	Designated Federal Official
DHHS	Department of Health and Human Services
DOD	Department of Defense
her	Electronic Health Record
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
FTE	full-time equivalent workers
GAO	Government Accountability Office
GDLs	Graduated Driver's Licenses
GWG	Global Workgroup
GHI	US Global Health Immunization
HAI	Healthcare Associated Infection
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HHS OCIO	Department of Health and Human Services Office of the Chief Information Officer
HIV	Human Immunodeficiency Virus
HSPD-21	Homeland Security Presidential Directive 21
ICU	Intensive Care Unit
IRB	Institutional Review Board
LA	Los Angeles
MAPPS	Media, Access, Point of Purchase/Promotion, Pricing, and Social Support and Services (MAPPS)
MCH	Maternal and Child Health
MMWR	<i>Morbidity and Mortality Weekly Report</i>
NAIC	National Association of Insurance Commissioners
NBAS	National Biosurveillance Advisory Subcommittee
NCD	Non-Communicable Diseases
NCPP	National Commission on Preventive Practices
NCQA	National Committee for Quality Assurance
NGO	Non-Governmental Organizations
NHSN	National Healthcare Safety Network
NTD	Neglected Tropical Diseases
OADC	Office of the Associate Director for Communication
OCIO	Office of the Chief Information Officer
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSTLTS	Office of State, Tribal, Local, and Territorial Support
PEPFAR	President's Emergency Plan for AIDS Relief
PHI	Public Health Investigator
PID	Pelvic Inflammatory Disease
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child HIV Transmission
PPACA	Patient Protection and Affordable Care Act
PPHF	Prevention and Public Health Fund
SHO	State Health Officials
SNAP	Special Needs and Autism Project
STD	Sexually Transmitted Diseases
STLT	State, Tribal, Local, Territorial
TB	Tuberculosis
UK	United Kingdom
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
USPSTF	US Preventive Services Task Force
VFC	Vaccines for Children program
WIC	Women, Infants, and Children

Welcome and Introductions

**Eduardo J. Sanchez, MD, MPH, ACD Chair
Vice President and Chief Medical Officer
Blue Cross and Blue Shield of Texas**

Dr. Sanchez called the Advisory Committee to the Director (ACD) meeting to order. He led those present through a round of introductions [Appendix #1: Attendance Roster] and emphasized the importance of members disclosing any conflicts of interests and recusing themselves from any discussions and / or votes pertaining to such conflicts. The following conflicts of interest were declared at the outset of the meeting, and ACD members were instructed to declare other conflicts of interests during the discussions / votes as they arose:

Dr. Greenberg: His department received funding from CDC indirectly through the D.C. Department of Health, the Elizabeth Glaser Pediatric AIDS Foundation, and the Association of Public Health Laboratories.

Dr. Mandl: His department receives CDC funding.

Dr. Rosenbaum: Her department at George Washington receives CDC funding, primarily with respect to vaccinations.

**Thomas R. Frieden, MD, MPH
Director, Centers for Disease Control and Prevention and
Administrator, Agency for Toxic Substances and Disease Registry**

Dr. Frieden thanked everyone for traveling to Atlanta for the ACD meeting, particularly given their busy schedules. In addition to the guests who would be presenting, he acknowledged the senior leaders in attendance from the Centers for Disease Control and Prevention (CDC), emphasizing what a “Dream Team” of public health professionals the agency is fortunate to have.

While the focus on “winnable battles” is an organizing principle of the efforts of CDC and some of the agency’s state and local partners, Dr. Frieden pointed out that it is also causing some controversy. Nevertheless, the agency has identified areas in which many lives and a considerable amount of money can be saved. He has developed five key priorities for the organization, which are to:

- Improve surveillance, epidemiology, and laboratory services
- Improve state, tribal, local, and territorial support
- Increase impact in global health
- Increase policy impact
- Maximize health benefits by reducing injury, disabilities, and death

In order to maximize health benefits, the agency identified six focus areas (e.g., winnable battles) where CDC wants to do more, which are as follows [<http://www.cdc.gov/about/winnablebattles.htm>]:

Healthcare Associated Infections (HAIs)

CDC is committed to eliminating preventable infections that occur as a function of medical or surgical conditions. HAIs are one of the top 10 leading causes of death in the United States (US), accounting for an estimated 1.7 million infections and 99,000 associated deaths each year. HAIs cost approximately \$30 billion per year and are highly preventable. CDC has in place the National Healthcare Safety Network (NHSN). Greater than half the hospitals in the United States are now reporting to the NHSN, which will help to improve the quality, quantity, and comprehensiveness of that reporting system, as well as contribute to prevention efforts.

HIV

CDC provides leadership in reducing new HIV infections through awareness of HIV status, prevention for positives, prevention for high risk negatives, and elimination of health disparities. HIV rates have been stable for many years. Understanding more about HIV can drive infections down.

Motor Vehicle Injuries

CDC actively supports evidence-based interventions such as primary restraint laws, graduated driver licensing, and DUI interlock devices to drive down deaths and injuries from motor vehicle crashes. There has been recent progress in this domain in that teen fatalities have fallen substantially in recent years. This is probably the result of a combination of factors, including the expansion of graduated driver's licenses (GDLs). While populations in other countries may drink just as much as those in the US and drive faster, the US has one-third of the fatalities in motor vehicle injuries. Motor vehicle injuries remain the leading cause of death in young people in the US, but these are preventable.

Obesity, Nutrition, Physical Activity and Food Safety

CDC is committed to addressing the epidemic of obesity and overweight in the US and improving the public's health through the promotion of good nutrition, physical activity, and a safe food supply. Obesity is getting worse very rapidly and is resulting in major social and economic costs. While they do not yet know how to reverse it, CDC is going to try. CDC is working in partnership with the Food and Drug Administration (FDA) and United States Department of Agriculture (USDA) to increase the safety of the food supply. CDC's work is largely focused on detection and response, but they want to move a few steps back in the chain to assist with prevention efforts.

Teen Pregnancy

CDC works to prevent teen pregnancies that contribute to poor health and negative social outcomes through evidence-based strategies, policies, and systems change. Teen and unintended pregnancy rates in the US are 5 to 10 times higher than in other countries that have just as much sexual activity as the US. Such pregnancies often result in the intergenerational transmission of poverty. Effective efforts in this area have the potential to drive rates down by at least 50%, and to subsequently have a major impact on reducing social inequality.

Tobacco

CDC is dedicated to reducing the death and disease caused by tobacco use and exposure to secondhand smoke.

Dr. Frieden stressed that although these domains were selected as winnable battles, this did not mean that other areas were not important. However, the winnable battles are areas about which much is known and significant progress can be made in reducing health disparities and the overall health burden from these diseases and conditions. In addition to domestic winnable battles, CDC has enumerated five winnable battles on the global front (e.g., prevention of Mother-to-Child HIV Transmission (PMTCT) and congenital syphilis; global immunization initiatives, including polio eradication; elimination of lymphatic filariasis in the Americas; tobacco; and motor vehicle injuries).

While CDC has a “Dream Team,” Dr. Frieden recognized that it was more a team of “Dream Individuals.” CDC, like most public health agencies, tends to operate in a decentralized manner in which the various programs within the agency have little to do with each other. In an effort to coalesce on common goals, CDC’s theme for the year is: *Prevention, Make it Happen and Make it Known*. They usually do one or the other, but rarely do both. Included is a series of areas: prevention wins; winnable battles; expanding partnerships; improving communication ability; and addressing health, policy, budget, and other challenges. Each of these areas has quantifiable directional targets to track progress throughout the year.

Carmen Villar, MSW
Designated Federal Officer, Advisory Committee to the Director

Ms. Villar offered her welcome to those present and acknowledged that she would distribute an overview of the winnable battles to the ACD members. While she said she has worked for CDC for 13 years, this marked her first ACD meeting. She joined the Office of the Director approximately five months prior to this meeting. Previous to that, she was overseas working in Africa for five years with the Global Acquired Immune Deficiency Syndrome (AIDS) program, prior to which she worked with many people throughout CDC who were in attendance. She stressed that she truly felt like a part of the CDC family, and expressed her excitement to participate in the ACD meeting. She requested feedback about anything they could do differently or better in the future, assuring everyone that they would refine the process moving forward.

Chlamydia in South Los Angeles

Sylvia Drew Ivie, JD
Chief of Staff, Board of Supervisors
Second District of Los Angeles County Government

Ms. Ivie explained that Los Angeles County is governed by five supervisors, each of whom has approximately two million people in his or her district. District One is East Los Angeles, District Two is South Los Angeles, District Three is the West Side, District Four is Long Beach, and District Five is the Antelope Valley / San Gabriel Valley. Ms. Ivie is located in the Second District, for which Mark Ridley-Thomas is the supervisor. The Second District’s population is comprised of approximately 50% Latinos; half a million African-Americans; 200,000 Caucasians; 200,000 Asian and Pacific Islanders (APIs); and 4,000 Native Americans. While there is a great deal of poverty in her district, there are also numerous assets. Martin Luther King Hospital is scheduled to reopen in 2012, a new public health facility costing \$20 million will be opened in 2010, and two new rail lines will bring people to this new public health facility. These efforts are underway at the same time they are trying to identify and solve the problems.

Chlamydia is disproportionately high in the Second District compared to the other four districts, and high rates of Chlamydia have been reported within the African American community countywide. Chlamydia is an old disorder that has been recognized since 1907, although it was not identified as a bacterium until 1963. The word *Chlamydia* means “to cloak.” One of the primary problems with Chlamydia is that 50% of people who have it do not know they have it because the symptoms are hidden.

With respect to sexually transmitted diseases (STD) rates in 2008, the Second District has the highest Chlamydia rate followed by gonorrhea and early syphilis. The Second District identified 14,000 cases in 2008, which was four times the rate of gonorrhea. In terms of how this is distributed amongst various racial and ethnic groups, African-Americans are by far the largest group in all districts as reflected in the following table:

	District 1	District 2	District 3	District 4	District 5
API	100	500	400	100	75
White	400	450	250	125	125
Hispanic	600	675	600	500	450
African American	1100	1400	1000	1200	1100

Chlamydia rates alone are probably the most alarming. Among teens aged 15 to 24 in the Second District, there were 6,792 cases (1,221 per 100,000 people) in 2008. While a portion of the rate may be attributable to increased testing, the problem is significant.

In terms of reported Chlamydia cases among 15- to 19-year olds by Los Angeles Unified School District (LAUSD) in 2008, Dr. Peter Kerndt (STD Program Director in the Los Angeles Public Health Department) was able to obtain signed permission from three-quarters of the parents for their children to be tested. Local District 7 (Washington Prep High, Manual Arts High, and Locke High) was found to have the highest rate at 1,447. To address this problem, a Second District STD Strategic Advisory Group was formed that was made up of the Los Angeles County Board of Supervisors, local government, and schools to assess the problem. The Strategic Advisory Group reviewed data with the Los Angeles County Department of Public Health (LAC-DPH) Sexually Transmitted Disease Program to identify trends, at-risk communities, and effective interventions. The group requested that County Counsel and the LAC-DPH take the necessary steps to enable a community outreach group (AIDS Health Care Foundation) to use an existing unused mobile van for targeted STD screenings and condom distribution. The group then began the process of implementing the proposed plan with LAC-DPH. The guiding principles of this effort are to:

- Empower Second District residents to make healthier choices through quality STD public education;
- Strategically target and intervene within most at-risk groups (including targeting teens in their own environment);
- Implement best practices already proven to work (such as the “I Know” campaign, the brainchild of Dr. Kerndt);
- Partner with trusted community outreach groups;
- Explore cost-effective approaches given budget constraints; and
- Leverage existing federal, state, county and private resources whenever possible.

The Second District intends to invest \$1 million in the “I Know” campaign and van over three years. Given the magnitude of the issue, Supervisor Ridley-Thomas decided to allocate supervisor discretionary funds to fund and embed Public Health Investigators (PHIs); develop the existing “I Know” campaign to align with the needs of the Second District Campaign: “I Know 2” Campaign; and utilize the mobile van for screenings, condom distribution, and “I Know 2” kit distribution. For PHI training, a two-week training course will be funded at the Department of Public Health, which is also a training site for the State of California. PHI job duties will be to conduct investigations to find cases of sexually transmitted diseases; interview infected persons to determine contacts or other persons at risk; locate and trace contacts; and convince the contacts to voluntarily seek diagnosis and treatment as required by applicable public health laws. The “I Know 2” Campaign will provide free home test kits to women between the ages of 12 and 25 for Chlamydia and Gonorrhea. Those who are interested can go to the “I Know” Campaign Website located at <https://www.dontthinkknow.org>. There they can complete a form to receive a free home test kit, which is mailed directly to the individual in a plain white envelope. The recipient follows the instructions and returns the test kit in a prepaid envelope, and can pick up their test results in one week either at the website or by telephone. If their test is positive, the website will assist them in locating clinics in surrounding areas that are free or charge a low cost. This website also provides a link to <https://www.inSPOTLA.org>, which will allow those infected to send anonymous e-mails to their partners. The website is completely bilingual. The “I Know” campaign has proven successful at reaching targeted communities. Of the 2572 kits ordered over a three-year period, the South and Metro areas had the highest percentages at 22% and 17% respectively (n = 1020). Of the total positives (n = 108), the positivity rates were highest in South Bay (27%), the South (25%), and Metro (17%).

In terms of the SDT mobile van, the group felt that it was important to allow a trusted institution to use an already available mobile van at no cost to distribute condoms and test kits to targeted Second District residents. They decided to use the AIDS Healthcare Foundation because it is known and trusted in the community as a private provider. Given that there remains some fear of public health in the community, working with community partners enhances the trust factor.

Ms. Ivie concluded that while research is underway to develop a vaccine for prevention of Chlamydia, doing so appears to be fairly distant in the future. While it is known that Chlamydia rates are high in the Second District, particularly amongst those aged 15 through 24, with quality health education and effective programs targeting young adults, they believe they can reduce the overall numbers and empower at risk groups to make healthier choices and take control of their reproductive health. This is imperative, not only because there is such a high volume of Chlamydia in the Second District, but also because it is potentially harmful to reproductive health and is considered to be an usher for Human Immunodeficiency Virus (HIV). This population also has large quantities of Trichomonas, which is an usher for HIV as well; therefore, Trichomonas needs to be reportable.

Discussion Points

Dr. Mandl requested further details regarding anonymized contact of partners through the internet.

Ms. Ivie replied that if an individual provides the name and e-mail for the partner, notification is sent from a central e-mail that does not even include “public health,” not from the individual’s e-mail. The plan is to tailor this for the Second District, so a determination must be made with respect to the address from which

such notices will be sent. The term “public health” carries a lot of baggage in the Second District, so they must be very careful. The partners must be identified in order to reduce the transmission rates, but a multi-faceted approach is being taken (e.g., implanted PHIs in community clinics, the mobile van, e-mail notification of partners, et cetera). A considerable amount of headway has been made such as simply determining approximate rates, and the campaign is anticipated to result in further success.

Dr. Rosenbaum wondered whether there are counterparts for South LA County in other parts of the country, and how CDC utilizes its communication resources when there are wonderful ground-up activities such as this in order to generate other efforts.

Ms. Ivie replied that there are an estimated 1 million cases of Chlamydia throughout the nation currently.

Dr. Frieden added that this is one of the core functions of the STD program and the Office of State, Tribal, Local, and Territorial Support (OSTLTS). With regard to Chlamydia, many health departments are utilizing numerous interventions and CDC is struggling to determine the impact of those interventions. The South Los Angeles program is very promising. The City of Philadelphia began a fascinating project that does not require active consent. All of the students are called into an auditorium where a presentation is given about STD and Chlamydia. They are then given a bag and cup and are told that providing a sample is their choice. Approximately 60% of the students provided a sample. The positivity rate was almost 10% initially. They were able to treat essentially every one of the students who was positive. After doing this for several years, they have observed a decrease in the positivity rate and this has resulted in many people being treated. Other jurisdictions have tried that as well. CDC has been strongly encouraging the use of partner-delivered therapy for Chlamydia. That usually requires a change in state law, but a significant proportion of women with Chlamydia are re-infected because their partners are not treated and are generally asymptomatic. Another challenging area is electronic notification. San Francisco has had a very active program of partner notification through the Internet. The Internet results in greater efficiency, but more needs to be done to analyze and optimize this venue. Many people now check their Facebook page but not their e-mail, and some websites are typically blocked in government institutions. These issues must be addressed as well.

Mrs. Berryhill inquired as to whether consideration had been given to involving the faith community. Ms. Ivie responded that the faith community is at the table in the advisory group and is part of the outreach process.

With regard to electronic notification, Dr. Botchwey asked how other districts and health partners communicate information in their media campaigns. Thinking about privacy issues and the sensitive nature of sex in our society, this

notification needs to be addressed sensitively. How do they manage the receiver's queries of how the health department found out about their sexual encounter without creating concerns for privacy? It seems that there are ethical concerns that must be dealt with.

Ms. Ivie replied that they would soon be facing these because this program is currently being launched in her district. It will be very interesting to see how cooperative the response is to submitting partner names. With young people, there may be multiple partners and they may not even know who all of their partners are.

Dr. Sanchez reminded everyone that it is now a post-Patient Protection and Affordable Care Act (PPACA) world. Many of those aged 15 to 24 will be insured either by expanded Medicaid Exchanges or will be on their parents' plans. The US Preventive Services Task Force (USPSTF) has made Chlamydia screening either an A or B screening recommendation. Conversely, there is the issue of anonymity and confidential care. A 24-year old may not want to go to the family doctor for this testing, so alternative access to services will be very important. Consideration must also be given to Accountable Care Organizations (ACOs), which are not mindful of and do not understand that there are outbreaks, epidemics, or endemics of infections like Chlamydia. This is an opportunity to make connections and put public health at the ACO table to demonstrate that there is value in public health, because the medical care delivery system will still have gaps that must be filled in order to reduce morbidity.

Dr. Bal requested that Dr. Frieden further discuss the push-back or controversy regarding the winnable battles.

Dr. Frieden responded that there is an old saying that "Every time I make an appointment, I create nine enemies and one ingrate" [William Howard Taft]. Those in areas not selected as a winnable battle questioned why they were not selected. One group that has appropriately highlighted that they have not received enough attention is hepatitis, and there has been a series of Congressional letters from Hepatitis groups. The winnable battles represent six priorities that are a focus at the CDC director's level due to their burden and winnability. Dr. Frieden has stressed that every area of the agency should think about what the winnable battles are within their own purviews.

Transforming Care at Kaiser Permanente

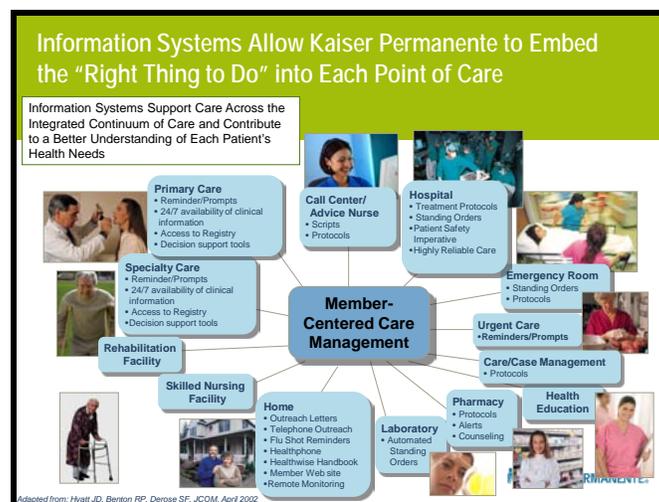
Benjamin K. Chu, MD, MPH, MACP
President, Southern California Region
Kaiser Foundation Health Plan, Incorporated, and Hospitals

Dr. Chu indicated that one of the areas that has always concerned and intrigued him is the

intersection of public and personal health. Reduced to its most elemental core units, the basis of care in America is still the doctor and the patient. There are millions of one-on-one patient interactions with doctors, with an average of four visits per year for each American at 10 to 15 minutes per visit, or an hour per year for patient / physician interactions. The underlying premise is that the sum total of those one-on-one interactions, and the \$2.5 trillion paid for healthcare, should result in a healthier population. The question regards how to change that. Merely covering more people and adding more units of care in a system that already has inadequate health results is unlikely to result in many improvements. A quantum leap is necessary so that the personal health care system really understands the winnable disease concept and truly engages in the preventive work necessary to result in a much healthier population.

Reporting on Kaiser Permanente's work over the last 5 to 6 years, Dr. Chu pointed out that while the data he was presenting was Southern California-specific, other regions reflect similar results. Kaiser Permanente is the oldest group model health maintenance organization, serving 8.6 million people in 8 regions across the country. This is not just a health plan, but is also a care delivery system. Kaiser Permanente's capitated payment model places as much emphasis on keeping people healthy as it does on caring for members when they are ill. Program wide, Kaiser Permanente has 8.6 million members (of which Dr. Chu is responsible for 3.3 million); 35 hospitals; 431 medical office buildings; 15,000 physicians; 167,000 employees; \$45 billion in annual revenue; 2,600 residents and interns; a \$4 billion health information technology investment (electronic health records); 60 years of providing care; and a focus on prevention of illness and disease.

Kaiser Permanente is an integrated healthcare system with interlocking parts. The doctors are in a for-profit medical group, but are exclusively contracted with one another. Thus, the health plan and hospital only contract with the medical group, and the medical group only contracts with Kaiser Permanente. The health plan, hospitals, and medical groups are separate but work together very well. Kaiser Permanente is highly unionized, so getting everyone to agree can be complicated. The electronic health record (EHR) allows Kaiser Permanente to pull together all of the various components of the continuum of care, as reflected in the following illustration:



While there are always glitches with EHRs, basically these allow Kaiser Permanente to be member-centric. Every single component of the care delivery system is hooked in, although this does not necessarily mean that everyone does the right thing. There can still be lack of

communication, specialists can still ignore what primary doctors say, notifications do not necessarily have to occur—but at least the system gives them a starting point. Work can be done on the systems to try to make changes. To that end, Kaiser Permanente tries to intersect public and personal health.

The various systems that feed into one common database include labs, hospitals, pharmacies, outpatient appointments, outpatient encounters, memberships, emergency departments, and immunizations. Information from 300 different legacy and other systems feed into a gigantic engine, and Southern California can organize the information on its 3.3 million patients into a set of different registries that they are learning how to make more dynamic and vibrant. The systems also allows them to risk stratify the population; identify subgroups needing specific care; utilize patient management tools; target panel lists for every part of the organization; use prompts / reminders for clinicians; generate letters and automated telephone outreach to members; monitor and process improvement measures and reports; and target health education and self-care support.

Kaiser Permanente's Registry for Chronic Diseases and Panel Management provides insight across disease spectrums. Examples of major registries that have been built with Southern California's 3.3 million people include: Asthma, Heart Failure, Diabetes, Coronary Artery Disease, Chronic Kidney Disease, Cardiovascular, Hypertension (n = 600,000 in Southern California), Panel Management, Bariatric Surgery Registry, and Total Joint Registry. Each member of the care team can access registry and panel management tools and play a role in addressing care gaps. Kaiser Permanente is approaching a 95% rate of compliance in collecting vital signs.

Kaiser Permanente members actively participate in their care through kp.org, a very robust internet access tool. Clinical libraries are accessible to patients in English and Spanish at a 4th or 5th grade reading level. Through this portal, members can make / change appointments, send messages to doctors, check lab results, access health information, access medical records, refill prescriptions, and make payments. There are also online modules on various topics (e.g., smoking cessation, weight reduction, et cetera) that are beginning to generate some data. Health coaches are also available through this system. More than 3.1 million Kaiser Permanente members have access to secure health information through this portal to which there are 230,807 average visits per day; more than 26 million test results viewed annually; more than 8 million prescription refills annually; and more than 10.6 million secure e-mails to physicians and other providers annually (23,000 daily).

Proactive encounters at every point of contact have revolutionized how Kaiser Permanente provides total health. All staff have responsibility for patients' total health. Not all patients see their primary care physician, and physicians alone cannot be expected to address all gaps. Every office encounter has been redesigned to optimize each patient contact. Areas of need are identified and acted on through various tools. Pre-encounters include proactive identification of missing labs, screening procedures, access management, kp.org status, et cetera; provide member instructions before visits; and contact the member and document the encounter in KP HealthConnect™. The office encounter includes vital sign collection / documentation, identifies and flags alerts for the provider, assigns a room and prepares the patient for necessary exams, and includes a post-encounter follow-up. Post-encounter patients are provided with an immediate after-visit summary, after-care instructions, follow-up appointments, health education materials, and information regarding how to access kp.org. Future post-encounters include follow-up contact and appointments per provider.

Dr. Chu emphasized that building tools is not enough. If they are kept private for just a single doctor's view, the actions necessary to make improvements will never occur. All of Kaiser Permanente's data are open to every doctor. Every doctor sees every other doctor's results, and everyone sees the medical office's results compared to others. Targets are set and some incentive reward programs have been developed to reward people for achieving certain results. Using its information technology tools, Kaiser Permanente Southern California has improved almost all major measures, including breast, cervical, and colorectal screenings; controlling high blood pressure; and osteoporosis management. For example, blood pressure control has increased from approximately 65% in 2005 to 84% currently. Colon cancer screening was approximately 45% in 2005 and is currently 70%. Breast cancer screening is currently close to 90%. Patient safety measures have improved steadily over the last few years and outperform some national measures with respect to hospital-acquired pressure ulcers, TLC core measures, blood stream infections, and mortality rates. By focusing on an osteoporosis disease management program spearheaded by an orthopedic surgeon (Healthy Bones Program), Kaiser Permanente Southern California achieved a 37% total reduction in hip fractures in older women. This is an extremely important accomplishment, given that hip fractures in older women lead to many complications including lack of mobility, inability to provide self-care, expensive nursing home care, and sometimes death. This is not just problematic for women. About 15% of Kaiser Permanente's osteoporotic hip fractures are in men.

The following table summarizes some of the improvements that have occurred in some key Healthcare Effectiveness Data and Information Set (HEDIS) measures in diabetes and cardiovascular screening from 2005 to 2010:

	2005	2010
Diabetes – A1c Screening	84.9%	92.57%
Diabetes – A1c Control (>= 9%) Lower rate is better	28.0%	23.76%
Diabetes – LDL Screening	91.5%	92.98%
Diabetes – LDL Control (< 100 mg/dL)	35.8%	62.57%
Diabetes – Retinal Exam	70.1%	73.39%
Diabetes – Nephropathy Monitored vs Medical Attention	80.0%	97.66%
CVD – LDL Screening	85.4%	95.12%
CVD – LDL Control (< 100 mg/dL)	60.8%	72.87%
Persistence of Beta Blocker After MI	79.4%	83.83%
Controlling High Blood Pressure	56.0%	84.23%

Using the National Committee for Quality Assurance (NCQA) calculator, the following table represents the number of lives Kaiser Permanente has impacted over a decade

Metric	Increase	Savings Per Decade
Cholesterol Control	21.5%	1727 Lives
Blood Pressure Control	39.9%	5479 Lives
HbA1C < 9.0	11.5%	1088 Lives
Smoking Cessation	17.0%	988 Lives
Breast Cancer Screening	11.1%	555 Lives
Cervical Cancer Screening	5.6%	36 Lives
Colon Cancer Screening	29.9%	4740 Lives
Total:		14,580 Lives

Though somewhat early to determine for certain, because of the increased rate of colon cancer screening, Kaiser Permanente has been diagnosing more cancers earlier and has observed a 6% reduction in Stage 4 cancers from 2005 to 2009. While some of this may be due to identification of more colon cancers and this may simply be early diagnosis at a higher stage, hopefully this will bear out and marked benefits will be observed from increased screening.

In conclusion, Dr. Chu emphasized that Kaiser Permanente wants the personal health care delivery system to become accountable for winnable diseases, and they want that system to change to target specifics. At the “end of the day,” the sum total of all of the personal interactions in the personal healthcare system should result in markedly improved community health.

Discussion Points

- Dr. Mandl requested further elaboration on Kaiser Permanente’s approach to performing screening functions throughout the organization, rather than waiting for the primary care physician, in terms of how that might be incorporated into a system that is not as encapsulated as Kaiser, and how that relates to the concept of the medical home that tends to put the onus on a specific site of care. Perhaps the medical home concept needs some caveats.
- Dr. Chu responded that the medical home certainly has good information systems, and he thinks everybody’s data should be shared with everybody else. Those who are achieving less successful results should be able to learn from those achieving better results. Pooling data is very important. Having a medical home is important, but the other prongs must be identified as well because many people do not go to the doctor. He does not even go to the doctor and he is a doctor. He does not believe it is equitable to put the burden entirely on the medical home to ensure that all patients receive all services needed, but they should try to address the gaps to some extent. Kaiser Permanente is fortunate to have a cohesive system with one common record. Specialists are pretty cooperative with the primary care doctors, and they truly want to do the right thing. That is not to suggest that specialists outside of that system do not want to do the right thing, but they simply do not have the time. Thus, a system must be configured such that office staff and medical assistants support physicians and specialists. When the data reveal gaps, targeted strategies should be utilized to address them.
- Dr. Frieden noted that Dr. Chu had advocated successfully for Kaiser Permanente to accept uninsured patients as a part of the community that is non-profit. It is known from the United Kingdom (UK) and the Massachusetts experience that having coverage is not the same as having health, and health disparities can continue. Healthcare disparities can be quite substantial even when there is coverage, which has major implications for health reform and maximizing benefits. He requested insight into Kaiser Permanente’s experience with the uninsured population in terms of the challenges, approaches, successes, and outcomes.

- Dr. Chu responded that Kaiser Permanente has a fairly robust racial and ethnic breakdown of all of its patients, although they do not yet have the ability to complete a socioeconomic breakdown. In terms of screening, nearly all racial and ethnic groups are above the 90th percentile in terms of screening. For some groups, the gap has narrowed. For some, the gap has stayed the same, but just a couple percentage points in reducing the gaps translates into a lot of people. While this problem is not solved, the overall systematic approach has improved everyone's results.

Global Workgroup Update and Discussion

Alan Greenberg, MD, MPH

Professor and Chair

Department of Epidemiology and Biostatistics

George Washington University School of Public Health and Health Services

Washington, DC

Dr. Greenberg reported that the Global Workgroup (GWG) of the ACD convened their first meeting the previous day. GWG is a new workgroup of the ACD that will provide recommendations to the ACD. GWG is charged with the responsibility of analyzing relevant issues and facts related to the new CDC Center for Global Health (CGH); and gathering information, conducting research, and drafting position papers and / or reports for deliberation by the ACD.

When the workgroup was first conceptualized, the CGH requested input in three focus areas, including strategy and structure, science and program, and external relations. Initially, three teams were created that were each to be comprised of two ACD members, two external experts, one international representative, and one DFO from the CGH. The initial meeting was to include all GWG members and CGH and division leaders; however, due to travel-related issues, some members were unable to attend. Therefore, a decision was made not to divide into workgroups at that point.

GWG members agreed to meet twice annually on the day prior to the ACD meeting, given that many members would be traveling to Atlanta anyway during that time. In addition, conference calls will be convened and e-mail correspondence will occur between GWG in-person meetings as needed. Each of the members was asked to make a three year commitment to serve on the GWG. Membership includes the following:

ACD Members

- David Fleming, Seattle-King County
- Alan Greenberg, George Washington University
- Kelly Henning, Bloomberg Foundation
- Mary Kelly, Shoppers Drug Mart
- John Seffrin, American Cancer Society
- Louis Sullivan, Morehouse University

External Experts

- Mickey Chopra, United Nations Children's Fund (UNICEF)
- Walter Dowdle, Task Force for Global Health (TFGH)
- Helene Gayle, CARE
- Ruth Levine, United States Agency for International Development (USAID)
- John McCormick, University of Texas School of Public Health (UTSPH)
- Andrew Weber, Department of Defense (DOD)

International Representatives

- Willis Akhwale, Ministry of Health in Kenya
- Richard Kamwi, Minister of Health from Namibia
- Yu Wang, CDC China

Designated Federal Officials / CGH

- Kevin DeCock, Director
- Patricia Simone, Principal Deputy Director
- Donald Shriber, Deputy Director / Policy & Communications

Unfortunately, the international representatives had to seek approval from their governments to be permitted to attend the meeting. While they all received approval, it came too late to organize travel for Drs. Kamwi and Wang. Although an attempt was made to connect them by phone, it was not successful. Dr. Akhwale was in attendance. Since much of CGH work is country-based, it is important to have the voices of countries included. Despite the expense to travel these individuals, this is critical and international representatives are eager to participate. To ensure that they are able to attend the spring meeting, arrangements will be made earlier.

During the first meeting, Dr. DeCock presented an overview of the CGH that illustrated the extensive growth of CDC's global health activities. There has been an increasing global epidemiologic impact of non-communicable diseases (NCDs) and injuries. While many people traditionally think of tropical medicine as pertaining to infectious diseases, there is an increasing trend toward non-infectious diseases becoming centrally important in terms of global health. Most of CDC's global field staff and funding are currently located in the four CGH divisions; however, global activities are scattered throughout CDC. CGH and its divisions have established a complex web of partnerships with different types of organizations, including numerous US government groups, bilateral and multilateral agencies, non-governmental organizations (NGOs), and foundations. Five "winnable battles" have been outlined for global health by the CDC Director that are influencing the thinking of the center and include global immunizations, mother-to-child HIV and syphilis transmission, lymphatic filariasis, tobacco control, and motor vehicle injury prevention. Three principal themes have been set forth for the CGH:

One CDC: Ministries of Health and partners should identify the voice of one CDC through the CDC country director rather than having multiple voices from multiple programs to try to focus the structure of the country.

Global Health is Global: Recognition on the part of headquarters that the impact and the action of the CGH are really in the field as opposed to in Atlanta.

Taking a Seat at the High Table: The impression of senior staff in the center is that in many important decision-making circles, CDC is not invited to the table to contribute to decisions regarding strategic and funding priorities for global health, and that opportunities should be sought to ensure that CDC is at those tables.

The major CGH activities include the Global AIDS Program, President's Malaria Initiative (PMI), Neglected Tropical Diseases (NTDs), Global Disease Detection, International Emergency and Refugee Health, Field Epidemiology and Lab Training Programs, Sustainable Management and Development Programs, and the Global Immunization Program (soon to move to the center). Other CDC global health activities included efforts in tuberculosis, malnutrition, safe water, maternal and child health, occupational health, tobacco prevention, toxic substances, and injuries and non-communicable diseases; although these are extremely important issues, the amount of funding in international full-time equivalent workers (FTEs) assigned to these activities is somewhat limited.

In terms of how the CGH operates, CGH's funding comes largely from defined programs such as the Global AIDS Program and the President's Malaria Initiative rather than discretionary funding. The Global Health Initiative is involved in critical interactions at a very high level. The impression is that although there has been a tremendous uptick in global health funding in the last 5 to 7 years, it may be leveling off due to economic issues. Through the President's Emergency Plan for AIDS Relief (PEPFAR) program, there is a strong effort to ensure local ownership of these programs with funding going directly to the field. In addition to CDC increasing its global efforts, there is now extensive engagement of other US government agencies, academic research institutions, and foundations to ramp up their activities in global health.

It was clear to the GWG that the CGH is impressive and off to a strong start. Integration of the divisions into the center appears to have gone very smoothly. Large, important, and visible programs are contained within this center. There is extensive technical expertise now located in the center. GWG members were also highly impressed by the capable and committed senior leadership of the center and the divisions, and thought it was an extraordinary asset for CDC to have "boots on the ground" with hundreds of CDC staff stationed in-country and in multilateral agencies.

In terms of envisioning the potential of the CGH in the years ahead, there may be an historic opportunity to be transformative and to envision and do something that has not been done previously. The center should become more than the sum of its parts and define and demonstrate its added value. The CDC legacy and the model of epidemiologic and laboratory capacity-building in the state health departments might be translated to the global setting with Ministries of Health, building on the existing vertical programs that are in place and broadening into public health programs in countries to increase the independence of Ministries of Health. There is also an opportunity to define and develop the agenda for NCDs and injury prevention in the global setting. It is important to seek some "quick wins" in the first few years.

There is also an opportunity to define and develop the agenda for non-communicable diseases and injury prevention in a global setting that focuses on populations served, and that is consistent with the overall CDC mission. Currently, the mission statement is about 10 lines long and lists many of its activities when the center was founded. Core programs (e.g., PEPFAR, PMI, NTD, and GHI) should be protected, while defining and building a longer-term vision. Specific goals should be created for non-communicable diseases and injury prevention that

could serve as the basis for seeking new resources. The voices of key CDC, USG, multilateral, and Ministry of Health partners should be included in the development of the CGH strategy. An organizational chart should also be developed that highlights the importance of country programs.

The importance of partnerships and developing a CDC strategic voice in global health also arose during the GWG meeting as important issues. It is critical to develop internal partnerships with other CDC centers to demonstrate how CGH can support and enhance their global work. Externally, CDC is known for its strong and trusted technical voice with multi-laterals at a country level. The creation of the CGH provides the opportunity to develop its strategic advocacy voice at the country, US government, and global levels. Consideration should be given to developing an agenda and a CGH unit to focus on partnerships. CDC cannot “do it all” so it must engage partners and increase awareness of CDC’s strengths in global health. As noted earlier, CDC must ensure that it has a seat at the table to help define future global health funding priorities in a post-PEPFAR era. USAID should be actively engaged to define complementary strengths and further integrate the global health development agenda.

In terms of next steps, a brief summary of the GWG meeting will be developed that will be circulated to the members of GWG. Other potential GWG members may be identified and invited to serve on the workgroup. The next GWG meeting will be convened in the Spring of 2011 the day before the next ACD meeting. The GWG will work to ensure increased global representation at the next meeting. GWG will also informally continue its dialogue with CGH to determine how GWG can be maximally helpful to the center.

Discussion Points

- Dr. Sanchez suggested adding to the GWG membership a representative from the US Mexico Border Health Commission, of which the Secretary of Health and Human Services, the Secretario de Salud de México, and the health officers of all 10 border states are members.
- Dr. Frieden thanked the workgroup for their efforts. Reflecting on the three presentations heard thus far, he highlighted the critical priorities for CDC and critical ways in which the agency could call upon the expertise of the ACD and the ACD workgroups. Chlamydia is an example of a mission that has major health inequalities and disparities that need to be addressed in creative and focused ways. One of the major challenges for public health in the coming years is to gnaw at an on-going challenge public health has never figured out, which regards how public health and clinical medicine can interact in order to strengthen each other. This has been a bedeviling issue spanning over 100 years. PEPFAR is a remarkable success. Bill Clinton has remarked on a few occasions that he would never have gotten the kind of bi-partisan support that the Bush Administration did to start the PEPFAR program. Many people have worked to get public health where it is in global health. From a technical and political standpoint, there has been an amazing coalition of bi-partisan support. A few years ago, some of the advocates pointed to some of the academics who began teaching public health to ask for support with “b” for billions instead of “m” for millions. The global health world presents unique opportunities to transform the world’s health. CDC has been involved in global health. It is in the agency’s DNA. In 1951, the agency started a Puerto Rico

research station to address science. In 1950, CDC conducted its first epidemic investigation in Winnipeg, Canada for the flood there. CDC has roughly a dozen centers or independent offices, roughly 70 divisions, and several hundred grants within those divisions. Virtually every division and almost every grant has some international activity. This is really striking throughout the entire organization. The hope is that the CGH will enable the agency to have a critical mass and strengthen the activities throughout the organization such that it is easier to plug into efforts in the global arena. The GWG exemplifies what CDC is trying to do with the ACD, which is to create sub-units to provide support and guidance to new units rather than trying to set up new advisory structures each time a unit comes on line. This should result in better cohesion and less bureaucracy.

- Dr. Fleming emphasized that the remarkable leadership and comprehensive array of staff in the CGH speaks to the wisdom of creating the CGH. Historically, CDC has had a lot of activity in global health, but the nature of that activity by virtue of the organization has been distributed in individual programs as technical work around specific issues. Though wonderful, it has been very difficult for the agency to work to provide comprehensive assistance to countries that are working to create national public health systems / institutes. Establishment of the CGH offers an opportunity to assist countries in building the cross-cutting capability needed at the Ministry of Health, provincial, and local levels. That is the promise and potential that bringing all of these wonderful people together in the same place in this organization allows.
- Ms. Rosenbaum suggested that they could learn a lot from countries that have national health programs, and she wondered whether this might fall within the purview of the CGH.
- Dr. Frieden responded that they could learn a lot from the experience of other countries. One of the ironies of the H1N1 response was that CDC realized that many developing countries were in a much better position to conduct a mass vaccination campaign than the US, where such a campaign had not been conducted in decades. Another example is cardiovascular disease prevention, probably the area where the most lives are saved in healthcare. Some other countries have virtually all of the medication titration where blood pressure and cholesterol is done by nurses or pharmacists. They are better, more efficient, follow an algorithm, and get it done. Even in the poorest countries, there is “task shifting” with nurses doing things that a doctor would generally do, community volunteers doing outreach that nurses would generally do, et cetera. Task shifting is a way of providing more care for less money. If done right, it has at least as high and sometimes even higher quality due to better communications skills on some of those levels. This is a core concept in global health, and if the US is to reduce healthcare costs, this will have to be a major part of the equation here. There are also important examples within the US.
- Dr. Seffrin pointed out that it was known from experience with tsunamis that NCDs have been neglected. Less than 2% of international philanthropy dollars are dedicated to NCDs according to WHO. The economics are frightening in developed and developing countries. In September 2011, a high-level meeting of the General Assembly on Non-Communicable Diseases is to be convened with the participation

of Heads of State and Government. CDC should be engaged in this meeting at a high level.

- Dr. Seffrin strongly emphasized the importance of partnerships. They must keep in mind how NGOs can be leveraged to make a difference in tobacco control, cardiovascular disease, et cetera.
- Dr. Frieden pointed out that Ministries of Health in developing countries may not be as central in terms of non-communicable disease as they are with the communicable diseases. In-country, advocacy groups, Ministries of Finance, Ministries of Revenue, Departments of Transportation, et cetera can sometimes have much greater influences on non-communicable diseases, which is why the Head of State issue is so important.

Policy Workgroup Update and Discussion

Sara Rosenbaum, JD
Chair, Department of Health Policy
Harold and Jane Hirsh Professor of Health Law and Policy
George Washington University
Washington, DC

Dr. Rosenbaum thanked Andrew Rein and his staff, who have done a wonderful job supporting the formation of the Policy Workgroup. The workgroup has convened one telephone conference. The workgroup members engaged in a fairly robust discussion about three possible roles that the Policy Workgroup could play in supporting CDC. Everyone felt that the most important effort would be to take cues from the needs that flow from the intrinsic structure, form, and mission of CDC and from Dr. Frieden's leadership.

One of the goals is policy advisement. A prime example of policy advisement would be in the areas of the six winnable battles in which CDC has charted a course. This workgroup has a diverse membership. Members have expertise across the range of public health policy and practice, and Ms. Rosenbaum envisions that the membership will grow as the workgroup's needs expand and / or change. A second role is that of a policy incubator in which the workgroup is essentially playing a "bubbling up" role for CDC—making a large environmental scan of major events as they potentially may affect public health policy and practice, selecting as a workgroup an issue or two to tackle (with the consultation of CDC), and developing that issue. A third role that came through very clearly and importantly is policy support. This is particularly important in terms of CDC's support of state and local health officials' capacity to analyze and inform policy discussions at all levels of government.

The bulk of the teleconference was spent on the workgroup's potential role as a policy incubator, especially because of the extraordinary opportunity presented by the Patient Protection and Affordable Care Act (PPACA). As an insurance lawyer, Ms. Rosenbaum spends most of her time talking about pooling risk and insurance regulations. However, she believes the way that PPACA needs to be understood is as a pooling of the nation's health. When the nation's health is pooled, a determination must be made about how to allocate the resources that become available from doing so, and how to make those resources work fairly and in accordance with the best evidence available about quality health care. Also essential in pooling

health is to make a nation healthier. Everyone will then depend upon the health of one another. One's ability to receive healthcare when needed is going to depend on how healthy the pool is. In many ways, PPACA is not only the most important public health statement that the US has adopted in decades, but also is a fundamental game-changer when understood correctly. This is why Ms. Rosenbaum is eager to use this opportunity to help train local health officials, teach others, and learn from nations.

She shared some examples of the kinds of transformational steps that ought to be flowing (e.g., the downstream consequences) of having made this momentous decision to pool health. The first is that this kind of decision has a fundamental effect on CDC's own mission and tasks. The prevention programs that CDC administers are typically funded with discretionary resources. The prevention and public health fund supported programs should be looked at in light of far greater coverage than before. Of course, there is still a substantial portion of the population without health insurance, so the transformation is not utter and total. Nonetheless, it is significant enough, particularly among the lower income population.

Ms. Rosenbaum is also a member of the Advisory Committee for Immunization Practices (ACIP). ACIP has been transformed by this experience because all of a sudden, its recommendations are not merely recommendations. Once adopted, these recommendations will become binding. For example, the ACIP charter specifically addresses its relationship to the Centers for Medicare and Medicaid Services (CMS) on the issue of the Vaccines for Children program (VFC). Now ACIP's relationship is to the Department of Treasury, Department of Labor, Department of Health and Human Services Office of Consumer Information and Insurance Oversight (OCIO), the new federal health insurance regulator, every state insurance department, and the National Association of Insurance Commissioners (NAIC). ACIP's reach is far broader than it was before in terms of speaking to other agencies. Its deliberative needs are also different. The same kinds of expertise are needed, but the effects of ACIP's deliberations are different. ACIP took a very important step earlier in the day with regard to improving the evidence base on which its deliberations rest. Thinking about how ACIP functions in a post-health reform world is an example of a CDC core mission that is being re-thought and reshaped.

Another major area under PPACA is monitoring and surveillance. US systems are very limited and there remain many gaps. Ms. Rosenbaum has come to fully understand this only as a result of work she has done over the past two years on childhood asthma. There are numerous problems when there is an inability to tell a community the burden of a particular condition on the health of their children and on the cost of healthcare in the community. Systematic knowledge at the community level where the pooling of health begins becomes extremely important in a system of national health reform.

Strengthening in financing represents another major area under PPACA. The US has had very spotty healthcare financing without very strong attention to what constitutes a good preventive benefit. It is long past the time when insurers took the position that insurance does not pay for prevention—insurance is all about the risks. The country does not think that way anymore, and understands that insurance actually makes preventive care affordable to people. Suddenly, PPACA is forcing everyone to think about preventive primary and secondary preventive benefits, and to bring some uniformity to that model. This is where CDC's expertise in prevention becomes absolutely crucial.

Insurance coverage design must also be taken into consideration. A remarkable example of that came out of the ACIP meetings. There has been a terrible outbreak of pertussis, particularly in California, and a number of infants have died. Already reported in the *Times* and

the *Post* earlier in the morning was that one of the recommendations focused on the critical nature of cocooning infants in this kind of situation because they cannot be immunized themselves. That is, it is absolutely vital to immunize everyone in contact with infants in order to keep them safe during the period of time when they cannot be immunized. That raises the question regarding whether there should be coverage of the immunization for parents, siblings, grandparents, caregivers, et cetera. Many questions of this kind are likely to be posed. Do we push on the edge of insurance coverage design, in the name of public health, to think about new designs that are terribly important as part of financing in ways that lift the health of the population even as they also flow to the personal treatment of an individual?

These types of issues are going to be faced in defining qualified health plans, plans that will be sold in exchanges, in terms of what constitutes essential benefits and who essential providers are. This is particularly important with respect to the management of chronic illnesses and conditions. One of the issues that must be confronted is the fair amount of movement among lower income populations between the Medicaid insurance market and the exchange market. Medicaid is preserved as a separate program. Based on some preliminary work Ms. Rosenbaum has done with a researcher at Harvard, the numbers of people who cross that divide every year may be as high as 50% of young adults. This is a tremendously high number, and it does not take much income fluctuation to push an individual from one market into another. Continuity of care also poses a major public health question. Will there be continuity of care for younger men and women, who are usually healthier in their prime child bearing years, and their children in many cases who literally find themselves mid-year moving from one plan in one market to another plan in another market because their source of subsidy changes. An essential question for public health is: How are we going to align these markets?

Implementing health care quality measurement is a major issue in PPACA. How will we use the CMS Innovation Center to address questions of performance measurement, particularly with regard to chronic illnesses and conditions? How do we make ACOs function in the way that Kaiser Permanente functions such that there is no wrong door for preventive care just like there is no wrong door for enrollment? How do we reach a very high risk population? The enrollment job potentially includes 32 million people, a major proportion of whom represent some of the most vulnerable members of society because they have depended greatly on public health over the years. Does enrollment and retention become a public health mission in communities? Is this a place where state and local health officials can partner with other resources in states to enroll people and retain in health coverage? What do we do about community health supports and promoting community health decision making? How do we engage communities in health planning to take maximum advantage of PPACA? One of the most remarkable changes in the law has been the role of tax exempt hospitals in society. The law clarifies in ways that have not been clarified before what the community benefit obligations of tax exempt hospitals are, particularly in the area of public health planning. How do we harness those resources to put them to work in aiding communities to develop a greater sense of public health?

Another issue regards the major investment that has been made in the National Health Services' Community Health Centers in terms of harness an expansion that is going to grow this program from 20 million patients today to almost 50 million patients 10 years from now. There is workforce redesign to consider. Task shifting, which Dr. Frieden discussed, is a major domestic issue. Many states' Scopes of Practice Acts lag well behind the best evidence on workforce confidence and capabilities. There are issues relating to employer wellness programs, the question of how to empower local and state health officials to be full partners in this discussion. Many state and local health officials are incredibly knowledgeable about public

health practice and policy with states and localities, but it is often very hard to see the larger national currents of which public health needs to be part of the core mission of this change. What do we, as a workgroup, do to support public health officials in their own development as knowledgeable and expert in health reform and all of its ramifications?

In closing, Ms. Rosenbaum emphasized that a considerable amount of the Policy Workgroup's time on its first teleconference focused on this issue of health reform being like a stone that drops in the water and makes ripples that are only beginning to be understood, and their belief that it is absolutely a core mission of CDC to help public health translate and serve as incubator of health reform and public health.

Ethics Subcommittee Update, Discussion, and Charge

Robert L. Hood, PhD
State Public Health Ethicist
Ethics and Human Research Protections Program
Florida Department of Health
Tallahassee, Florida
Chair, Ethics Subcommittee

Dr. Hood reported that currently the Ethics Subcommittee is embarking on two projects. One project involves supporting state, tribal, local, and territorial health departments in their efforts to address public health ethics issues. The other project involves seeking input on the ventilator document presented during the last ACD meeting.

Regarding the first project, the Ethics Subcommittee has started reaching out to states to assess their public health ethics concerns. Thus far, they enlisted the help of Regional Health Administrators, and met with two groups of State Health Officials (SHOs) in Regions IV and VI on September 10, 2010. They held a webinar with SHOs in Regions VII and VIII on October 1, 2010. The purpose of these meetings was to share information about public health ethics; learn about the key ethical challenges facing state health departments; share information on ways these issues have been addressed; and hear thoughts about what CDC can do to assist health departments in addressing these issues in the future. SHOs regularly address public health ethics issues in practice. It is part of the everyday fabric of public health. Often times, the ethical issues go as smoothly as the practice of public health. While they are not noticed, they are there. Sometimes, the ethical dimensions become ethical tensions or problems. This has been observed in a couple of cases, such as in 2005 when there was a shortage of the seasonal flu vaccine. Concern about how to allocate ventilators during a severe pandemic when there may not be enough for everyone is another difficult issue that raises ethical concerns. Part of the role of public health ethics is to identify and articulate ethical points to consider to be used as a framework to systematically address these types of issues, tensions, and problems. In today's climate, anything that can further public conversations about hard issues is important.

The ultimate plan is to talk with state and territorial health officers, tribal health officers, and local health officers from across the 10 HHS regions. To that end, a number of partners have been engaged, including the following:

- CDC Office of the Associate Director for Science
- CDC Office of State, Tribal, Local, and Territorial Support
- CDC Public Health Ethics Committee
- Association of State and Territorial Health Officials
- National Association of County and City Health Officials
- HHS Regional Health Administrators
- CDC Tribal Consultation Advisory Committee

The common public health ethics challenges identified by SHOs to date included the following: policy / legislation / politics; resource allocation; data use and management, including privacy and confidentiality protection; control of infectious diseases; community engagement; and addressing the health needs of undocumented residents. General themes which arose were that it is important to address the “everyday” public health ethics challenges, not just the large, difficult issues. It is also important to assess ethics as part of the health department accreditation process, and to address issues that cross regions and / or states. In addition, there continues to be uncertainty about how to best use the Public Health Code of Ethics.

They learned that ethics is addressed in different ways among various state health departments. Some have ethics committees and much of that work has been based upon preparedness activities, particularly pandemic influenza. Other agencies have tried to implement ethics consultation programs. Many have partnered with academic medical schools and others. The most common way that states are engaging in these ethics conversations is informally, either as discussions among health officials or as informal discussions inside the agency. They heard from many people that there needs to be more structured versus informal discussions. SHOs felt that CDC could help in a number of ways including sponsoring training on public health ethics, developing case studies, facilitating discussion among health officials, developing a public health ethics consortium, and providing funding for development of public health ethics infrastructure. The next steps are to continue conversations with SHOs. Webinars with Regions I, II, III, and V have been scheduled. Webinars will also be initiated with tribal and local health officials, selecting representative samples from the 2000 to 3000 local health departments. In addition, they will prioritize ethics issues and develop useful tools for addressing them.

In terms of progress on the ventilator ethical considerations document, the document has been revised to clarify its intent as ethical points to consider rather than as policy guidance. A draft plan has been developed for dissemination and input, and the document has been discussed with State Pandemic Preparedness Directors. Input from the State Pandemic Preparedness Directors has been that states understand that there is a need for public health officials to develop triage plans that are informed by ethical principles. In addition, states need assistance with regard to how to engage the public and the media in a discussion about allocation of scarce resources. The Ventilator Ethical Considerations document will be disseminated through existing and established networks (e.g., grantees and stakeholders involved in crisis standards of care planning; pandemic influenza grantees; NACCHO Preparedness, Pandemic Influenza, and Infection Control Workgroups; ASTHO Preparedness and Infection Control Policy Committees; and National Hospital Preparedness Project awardees). Some new opportunities will be utilized for new input and comments (e.g., a weekly OPHPR newsletter to public health program directors and monthly ASTHO calls).

Discussion Points

- In terms of non-communicable disease, Dr. Sanchez pointed out that the issue of personal responsibility versus societal or policy intervention must be addressed. Those in state health departments need some cover, part of which might be a code of ethics that gives them the ability to say, “This is what I am charged to do. I am the messenger. Do not shoot me. This is what the information is.” This is tough to do in the political environments in state and local health departments. In the aftermath of bioterrorism, CDC created a Legal Workgroup that provided legal counsel for state health departments. He wondered how they might play a role in document dissemination.
- Dr. Hood responded that he would explore adding the Legal Workgroup to the dissemination resource list. With respect to a code of ethics, one of the ways of organizing public health ethics is to determine the dynamics between the role of the state in protecting the public good—public health versus individual liberty, or freedom of individuals. This holds true with non-infectious diseases as well and the state must play a role in addressing the tension between directing the public good versus limiting the people’s choices and freedoms. The ethics rationale for limiting people’s freedoms has to do with harms—their potential harms to other people. That is the fundamental legal and moral issue. The harm from obesity is not a contagious impact on the public—it is an economic one. One perspective is that it is going to be hard to make that case. A considerable amount of work has been done to assess the concept of libertarian paternalism as a potential framework (e.g., focusing on encouraging as opposed to punishing people).
- Dr. Climan pointed out that in a way, ethics ties in with global health. People are being bankrupted around the world with disease. Communicable disease is not where the economic impact is. Ethics ties into this because economics creates harm to others in that it stops other initiatives from moving forward, including prevention initiatives. If CDC and others do not take an active role in non-communicable disease prevention, the dialogue moving forward is unlikely to change. The US and CDC may cease to be looked to for leadership. Influence is going to come from places that it has never come before. Billionaires are going to spend enormous amounts of money to influence policy because of their own interests and their own desire to leave a legacy: 30- to 40-year olds with unlimited amounts of money are going to attack the fundamental problems in terms of delivering healthcare. Therefore, public health must arrange its agenda to align with the forces that are going to come to bear in the US. Otherwise, public health is not going to have a seat at the table. Therefore, it is imperative to clarify the role of CDC at this time.
- Dr. Delbanco wondered where the voice of the consumer was in terms of ethics. The political landscape is changing rapidly with the Tea Party, which has a very different view of how ethics should be defined for the public. How has CDC engaged the public in a discussion about these issues? There do not seem to be any politicians running on a public health platform. Perhaps it would be beneficial to engage the public in this discussion.

- Dr. Hood replied that the Ethics Subcommittee has given this a great deal of thought. Their perspective is that the Ethics Subcommittee's role with the ventilator document is to articulate a series of points that can be considered. This is a toolkit that can be used by state and local health officials to interact with their communities in ways that are transparent, engage the community, and are fair. In this work, CDC's customers are SHOs. During a recent bioethics conference, there was a lot of discussion about public engagement. There are ways that the Ethics Subcommittee could comment on the best practices about how to have discussions pertaining to these complicated, value-laden, controversial, issues that are inflammatory. The Ethics Subcommittee serves at the request of ACD and the Director, so they will certainly focus on whatever topics the ACD and Director specify.
- Dr. Bal pointed out that Bloomberg and Gates are "putting their money where their mouth is," so there is no argument between individual liberties and community responsibility. They understand the translation of science to public policy in government, whether it is in India or the US. The minute that something is made a science / data issue, everyone wants more data. By the time there are more data, the topic is no longer hot. Drs. Bal and Seffrin wrote an editorial specifically on that topic 12 years ago entitled, "What Don't We Know and When Didn't We Know It?" In his opinion, the prevention funds with ACD should be allocated to CDC. There are more than adequate skills and expertise within CDC.
- Regarding the relationship between science and policy, Dr. Hood said he thought they lived in a world where people believe it is important to have conversations with fellow colleagues. Disagreement is good in that it provides a check on overenthusiastic people. He is hearing from SHOs that it is sometimes helpful to explicitly draw attention to the ethical dimensions of why people are disagreeing.
- Dr. Fleming urged the Ethics Subcommittee to think about and prioritize the issues that need to be addressed. Public health interventions to address health disparities should be high on that list. Consideration should be given to the extent that disproportionate investments should address health disparities. More dollars are being allocated for small proportions of the population, which is exemplified by the recent steps to restrict food stamps to disallow the purchase of sugar-loaded beverages. Consideration should be given to the relative effectiveness of preventive interventions for certain populations.
- Dr. Sanchez pointed out that such issues have created interesting alliances and interesting enemies. The interesting alliances include the food industry and people living in poverty. Some of the interesting enemies are Republican elected officials who have asked him point blank in committee hearings why they do not use what has been done in the Women, Infants, and Children (WIC) program as a model to change how resources are used for the Supplemental Nutrition Assistance Program (SNAP). Discussing this in an ethical framework would be very interesting. There are those who want to do something about childhood obesity and childhood poverty, and people are pitted against one another on this issue. Right now the discussion is more visceral than intellectual, and no progress is being made.

- Dr. Frieden said that as an observer of these issues, he thought that one of the challenges was that there are some who have the perspective that if actions are taken at the governmental level, that somehow undermines or lets personal responsibility off the hook. There are others who believe that individuals cannot do anything when the government is not doing its job. He thinks both perspectives are wrong. Government has a responsibility to ensure that the default choice is the healthy choice, and individuals have a responsibility to select the healthy choice.
- Dr. Seffrin posed the question: When does an intervention become a moral imperative? For him, this related to winnable battles and making it happen. Tragically, it is well-established that tobacco will kill a billion people. This has been demonstrated, which to him makes cessation interventions a moral imperative. Priorities should be set based on areas in which results can be guaranteed to make a huge difference, and that should fall under the moral imperative.
- Dr. Sanchez observed that no one took issue with government regulators saying that there ought to be indoor sinks and toilets in public spaces. That has been a major contributor to reduction in the transmission of communicable diseases, and is now a default choice that is taken for granted. Perhaps they simply need to reframe the conversation about non-communicable diseases to say that they are seeking the Holy Grail equivalent of sinks and toilets on the non-communicable side until they reach the same level of acceptance as there is for indoor sinks and toilets.
- Based on the discussion, and using diabetes as an example, Dr. Sanchez suggested that perhaps the Ethics Subcommittee should be charged to provide a preliminary overview to the ACD on ethical issues related to non-communicable disease prevention and control and an ethics framework to guide future CDC programs, activities, and initiatives.

Motion: Ethics Subcommittee Charge

Dr. Botchwey made a motion to charge the Ethics Subcommittee to provide a preliminary overview to the ACD on ethical issues related to non-communicable disease prevention and control and an ethics framework to guide future CDC programs, activities, and initiatives.

Dr. Mandl seconded the motion. The motion carried unanimously and the Ethics Subcommittee was so charged.

State, Tribal, Local, and Territorial Workgroup Update and Discussion

Overview

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

Dr. Fleming reminded everyone that the Office of State, Tribal, Local, and Territorial Support (OSTLTS) is one of the new sections that was recently created at CDC, which will be supported by the State, Tribal, Local, and Territorial (STLT) Workgroup. Because of the cross-cutting nature of OSTLTS, the STLT Workgroup believes that there are three elements to its charge. First, and most directly, it is to provide OSTLTS with advice and input on public health practice and priorities. Second, because this is a cross-cutting office, an additional function is to provide input and advice more generally to CDC as an organization, using OSTLTS as the conduit for that. The third element is to determine whether there are other parts of CDC that could benefit from the perspectives of on-the-ground practitioners who are translating public health science and innovation into practice.

With respect to populating the STLT Workgroup, they wanted to include experts in public health practice; as well as various constituencies of state, tribal, local, and territorial organizations. They also wanted to ensure that those selected to serve on the workgroup were vetted through national organizations to ensure that they were, in fact, good representatives of the national perspective. There was an outpouring of interest to serve on this workgroup from some of the best and brightest people in the country. The geographic diversity of the group is remarkable. Working group members include: John Auerbach, David Fleming, James Baird, Dileep Bal, Bruce Dart, Thomas Farley, Jonathan Fielding, M. Rony Francois, Melissa Gower, Paul Halverson, David Lakey, Carol Moehrie, Karen Remley, Lillian Rivera, Eduardo Sanchez, Mary Selecky, H. Sally Smith, Julia Sheen-Aaron, and Anna Whiting-Sorrell.

The STLT Workgroup convened a meeting on September 27, 2010. The primary focus of the agenda was to help OSTLTS deal with a couple of issues that needed immediate attention, and to brainstorm about the challenges and opportunities CDC is currently confronting that this workgroup might help to deal with in the future. A specific issue with which OSTLTS has been grappling regards identification of best practices and how to transform what is known about these best practices into actual practice at the state, tribal, local, and territorial levels. Another current project is that of the report / score card and how the results from these can be provided to public health practitioners in a way that helps rather than hurts their practice.

What OSTLTS Heard

Judith A. Monroe, MD, FAAFP
Deputy Director,
Office for State, Tribal, Local, and Territorial Support

Dr. Monroe further explained that there is an effort underway that is being driven out of OSTLTS to work within and across CDC to define best practices, particularly given that this work has not ever fully come to fruition at CDC. OSTLTS brought this to the STLT Workgroup in order to obtain their input and advice. One very loud message that OSTLTS heard was that best practices need to come from / be driven by the field and should not be CDC-centric. The

workgroup also recommend that selection criteria be very explicit, and that they align with the *Community Guide*. Categories under consideration include: Emerging, Promising, Best, and Good. While it was suggested that anything recommended as a best practice should be able to go to scale, concern was expressed about rural communities. CDC was asked to remember that this is a diverse country and that one size does not necessarily fit all. It was suggested that administrative best practices be included, and that fiscal and political environments be considered. Jurisdictions do not want to be punished or made to feel that they are not doing a good job when there are circumstances beyond their control or they need special technical assistance to help overcome highly complex issues. A primary focus should be to pay attention to closing the gap in what is known and what is practiced in order to determine the reasons that there continue to be gaps.

The STLT Workgroup also discussed the Prevention Status Report, which began as a Score Card. Dr. Monroe did not hear full agreement among the STLT Workgroup members on this topic. Some members were very supportive and excited, while others were more hesitant. There did seem to be agreement that the process should be transparent, use sound methodology and measurement, and include customized reports. The rollout should encourage continuous quality improvement. There was a good sense among the workgroup members that Prevention Status Reports could advance national priorities if the information is placed in the right hands. An issue that arose several times is that data collection systems, such as the Behavioral Risk Factor Surveillance System (BRFSS), need to be upgraded, particularly given that much of the data for status reports is derived from these systems. It was suggested that more resources be allocated to upgrade / modernize such systems in order to reach those who have cell phones, et cetera. The workgroup members emphasized that all reports should be based on sound data collected into today's world.

Also discussed was PPACA in terms of the future of public health, what transformations need to occur, and what the fundamental role of public health departments of the 21st Century would / should be. STLT Workgroup members felt strongly that it will be important to demonstrate that public health activities are complementary to more people being insured. Public health's value must be demonstrated. Public health has not been the centerpiece of health reform, although public health can improve quality and reduce cost. It is imperative to make public health's strengths visible. Workgroup members believe that CDC can play a role in doing that, and should be a leader in this effort. The STLT Workgroup also felt that the intersection of public health and medicine is very important.

There was a considerable amount of discussion regarding the importance of taking a systems approach, the context of winnable battles in each jurisdiction, marketing public health, helping jurisdiction adapt to their new roles, focusing on integrated systems, quality improvement, strengthening analytical capacity, and the need for more public health infrastructure funding. The message regarding resources was that categorical funding streams create inefficiencies.

Looking Into the Future

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

Dr. Fleming emphasized that this was quite a remarkable meeting for one day, which resulted in considerable input. Looking into the future, there is a need to prioritize the work of the committee. In the context of continuing to provide advice and input directly to OSTLTS and

CDC, the workgroup feels that there needs to be an on-going focus on the issue of health care reform and how public health best fits within that. The STLT Workgroup should work carefully with the Policy Workgroup to assess the opportunities and challenges, and there have been some initial discussion about this. In addition, the STLT Workgroup needs to review CDC's entire portfolio more broadly, not just the financing that occurs through OSTLTS, to determine whether there are ways that financing flows can be improved to maximize state, tribal, local, and territorial public health practice. There should also be a focus specifically on the OSTLTS investments as they support governmental public health practices. The next STLT Workgroup meeting will be utilized to hear input on the highest priority issues that the field believes should be part of the mission of OSTLTS. A lot of work was done initially with regard to some of the urgent issues, but now there is time to step back and think about other important issues.

In terms of how the ACD workgroups should be operating, there is clearly major value in convening meetings with informal input and discussion exchange between the workgroups and the various offices. In addition, there is the role of ACD in terms of issuing specific charges to the workgroups as necessary, with the expectation of a report back to the ACD. For example, consideration could be given to how existing and new granting opportunities could be structured to increase the efficiency and effectiveness of practice at the local level. There is an on-going conflict regarding competitive funding versus ensuring that even those areas that cannot be competitive will receive the resources needed to address their health burdens. For categorically funded programs, there need to be clear deliverables related to that specific program, making it as easy as possible for state, tribal, local, and territorial levels to use those resources in a way that would also build necessary infrastructure. The question is: Should the STLT Workgroup develop specific recommendations for ACD to consider relative to maximizing the efficiency and effectiveness of CDC funding as it pertains to developing capacity at the state and local level?

Discussion Points

- Dr. Frieden pointed out that in addition to maximizing the efficiency and effectiveness of the grants program, consideration could also be given to how OSTLTS can maximize the effectiveness of its work. He deferred to Dr. Monroe, given that the purpose of the STLT Workgroup is really to help her manage the unit and the staff to accomplish its goals, which are agency-wide. As Deputy Director, she has a purview over all of the centers to try to improve grants, technical support, and other forms of assistance.
- Dr. Fleming inquired as to whether the desired work style for the workgroups is to create a product of some sort (e.g., reports, recommendations, et cetera) that would ultimately be presented to the ACD for discussion and adoption, or if the preference for all of the work of the subgroups to be between the workgroups and the entities they are advising.
- Dr. Sanchez offered a friendly amendment to the charge that on the screen, which would be to produce recommendations about how to provide assistance, and frame new and existing grants to maximize resources to develop the needed capacity throughout the STLT community. In other words, it may not just be about money. It may be about how to build capacity at the state, tribal, local, and territorial levels.

- Dr. Greenberg was struck by the similarities between the role that OSTLTS may be playing interfacing with the local health departments and establishing uniform best practices, and the vision that Walter Dowdle and others were expressing about the potential role the CGH could serve in developing the capacity of the Ministries of Health to function more effectively on minimum capabilities for public health. The notion of “twinning” came to mind. CDC could play an honest broker role in partnering some of the more developed state, tribal, local, and territorial health departments with some of the more developed Ministries of Health such that there would be an interface between OSTLTS and the CGH.
- Dr. Fleming briefly mentioned the idea to Dr. DeCock the previous day. The idea is a great one, and changing the notion of global health from a one-way street in which the US knows everything and provides that information to people in other countries to a two-way street could result in substantial direct benefits. Dr. Monroe agreed.
- Dr. Greenberg pointed out that there is an imbalance in matching countries with states, but CDC can be transformative with the vision of linking health departments together or linking ministries together from a public health standpoint.
- Dr. Sanchez pointed out that there are four states that border six other states, and there is an opportunity to learn firsthand in the US about some ways that that could be done, which could then inform the activities of OSTLTS and CGH. The charge to the STLT Workgroup would be to produce recommendations regarding how to provide assistance and frame new and existing grants to maximize resources to develop capacity throughout the STLT community. This may include technical assistance to help people figure out how to make better use of what they already have.

Motion: STLT Workgroup Charge

Dr. Botchwey made a motion to charge the STLT Workgroup to produce recommendations regarding how to provide assistance and frame new and existing grants to maximize resources to develop capacity throughout the STLT community. This may include technical assistance and / or other strategies other than funding to help people figure out how to make better use of what they already have. Dr. Mandl seconded the motion. The motion carried unanimously.

- Dr. Frieden commented that over the next few years, enormous challenges will be faced with finances, and the states are going to bear the brunt of that. They have to balance their budgets, revenues are plummeting in many cases, and public health is not very visible when there are other issues of concern. That means that the public health community is going to have to be advocates for state, tribal, local, and territorial public health. Can public health help with some of the actual cost savings with healthcare? Public health has a tendency to think

that this is not its job because public health is about prevention, access, and getting health value out of health dollars. Society cannot afford the increasing healthcare expenditures however this is structured. A very experienced person said to him recently that in many states, investments in higher education and infrastructure are being crowded out by health care costs. There are vast challenges in dealing with the fiscal imbalances of the states, not to mention the federal government. One of the major challenges of OSTLTS is to be effective partners in helping to protect state public health during what are going to be very lean years.

- Dr. Sanchez thought this would be a unique area with which the STLT Workgroup could offer assistance. How value / return on investment are articulated will be very important. They must make the case that the public health work that occurs at the local, state, and federal levels reduces the burden of disease and / or reduces the demand for expensive medical care. How do we turn that into a discussion about the dollar currency that says this has to be funded in order to realize that opportunity?
- Dr. Fleming pointed out that most of the savings in healthcare reform are going to be realized in non-communicable, chronic diseases. Most investments in public health are not in the chronic disease area. There is major tension at the state, tribal, local, and territorial levels as budgets are being cut and resources coming in are being used to backfill programs versus developing new programs that align with health reform.
- With regard to funding, Dr. Bal commented that there are lumpers and splitters. The lumpers distribute money in a brown paper bag in small bills and permit it to be used according to discretion and need. Splitters are about categorical funding. He is a splitter because throughout the 1970s in Arizona, 25 years in California, and the last 5 years in Hawaii, he has at various times been ripped off by supervisors, governors, or both. With respect to the non-communicable disease issue, there is a disconnect that starts with a dissonance in the funding. Funding is still very heavily communicable disease oriented. He requested that Dr. Frieden speak to this issue.
- Dr. Frieden emphasized that much of how funding is allocated is dictated by Congress, which provides money with great specificity. CDC has advocated for specific dollars to strengthen public health infrastructure as part of the Prevention and Public Health Fund (PPHF). The PPHF is crucial, but it is difficult to explain what those infrastructure dollars will do in a way that makes people excited about them. One potential resolution is to strengthen infrastructure and systems by implementing specific activities and achieving specific outcomes.

National Biosurveillance Advisory Subcommittee Update and Discussion

Background / Overview

Dr. Pamela Diaz
Director, Biosurveillance Coordination Unit (BC)
CDC, Designated Federal Officer for NBAS

Dr. Diaz reported that on October 18, 2007, Homeland Security Presidential Directive-21 (HSPD-21) was released by the White House. HSPD-21 called for a nationwide biosurveillance capability, as well as the establishment of an advisory committee to the federal government on issues related to biosurveillance. Specifically, HSPD-21 calls on the federal Department of Health and Human Services (DHHS) to "establish an operational national epidemiologic surveillance system for human health, with international connectivity where appropriate, that is predicated on state, regional, and community-level capabilities and creates a networked system to allow for two-way information flow between and among federal, state, and local government public health authorities and clinical health care providers." The Secretary of DHHS was tasked with leading that effort in collaboration with other agencies. HHS tasked CDC with the leadership role, establishment of the advisory committee, and addressing issues related to HSPD-21 and biosurveillance.

NBAS was formed on May 1, 2008. The membership of the committee was comprised of a mixture of public and private stakeholders with diverse backgrounds and perspectives—people who were leaders in their area, with great minds, who had a lot to offer. At that time, Dr. Larry Brilliant, President of google.org, was the chair of the subcommittee. The first iteration of the subcommittee was divided into eight task forces. Federal liaisons and CDC subject matter experts (SMEs) agreed to provide support to the subcommittee. Early in 2010, Dr. Engel accepted the opportunity to become the co-chair of NBAS with Dr. Brilliant. Dr. Brilliant stepped down in July 2010, and Dr. Ian Lipkin then replaced Dr. Brilliant as co-chair. This year NBAS is being overseen by Dr. Engel and Dr. Lipkin, both of whom were members of the original NBAS. The Biosurveillance Coordination Unit (BCU) was formed at CDC to provide support to the subcommittee, with Dr. Dan Sosin as the original leader of that unit. The BCU was established to respond to the mandate of HSPD-21 regarding the development of a nationwide, robust, and integrated biosurveillance capability.

To manage and support the biosurveillance strategy development and the NBAS, the Biosurveillance Coordination Unit (BCU) was constituted within CDC. The BCU is comprised of a small core of individuals who are tasked with many of the other mandates associated with biosurveillance in HSPD-21, as well as supporting the NBAS in its efforts. That administrative support led to the development of a collaborative document titled the "National Biosurveillance Strategy for Human Health" and a supporting concept plan.

Throughout 2009, NBAS used a variety of research and fact-finding activities to assess the charges of each of the eight task forces and to develop task force reports. The task forces completed the first round of those reports in January 2009. The first NBAS report to be developed from those was titled, "Improving the Nation's Ability to Detect and Respond to Twenty-First Century Health Threats." That report was submitted to the ACD in March 2009, was approved by the ACD on October 7, 2009, and was published on October 16, 2009.

The first NBAS report laid out the following five high level recommendations:

- The Executive Branch must define the strategic goals and priorities of federal investments in biosurveillance activities and technologies, and implement a plan to achieve, fund and periodically assess progress toward these goals. To accomplish this, the White House should establish an Interagency Biosurveillance Coordination Committee ("the Committee").
- The US National Biosurveillance Enterprise must include global health threats in its purview and scope.

- The federal government must make a sustained commitment toward ensuring adequate funding to hire and retain highly competent personnel to run biosurveillance programs at all levels of government.
- Government investments in electronic health records and electronic laboratory data should be leveraged to improve how they serve biosurveillance and public health missions.
- The federal government must make strategic investments in new technologies (e.g., genomics, supply chain management, visualizations, display dashboards) to strengthen US biosurveillance capabilities.

The impact of the NBAS's first report can be seen in several areas. First, the report has influenced the biosurveillance strategy documents. Versions 2.0 of the National Biosurveillance Strategy for Human Health took into account NBAS's first report. The NBAS's report also influenced the supporting concept plan, particularly, the information NBAS provided with regard to governance. The first report also influenced the BCU's efforts within CDC, especially the development of the National Public Health Surveillance and Biosurveillance Registry for Human Health.

There have been several impacts on governance considerations beyond the recommendations from the first NBAS that are being felt within the federal government, given that three of the first NBAS members now hold very high positions within the new administration. Dr. Tara O'Toole is the Undersecretary for Science and Technology at the Department of Homeland Security, Dr. Farzad Mostashari is the Deputy National Coordinator for Programs and Policy at the HHS Office of the National Coordinator for Health IT, and Dr. Peggy Hamburg is the Commissioner of FDA. In addition, the impact on governance has been felt with a recent Government Accountability Office (GAO) report that also called for a focal point within the federal government to address biosurveillance. This recommendation has recently been gaining some traction in discussions across the federal government. The NBAS's first report also had an impact on establishing broad concepts. The five recommendations laid the groundwork for a more detailed examination in the second report. The first report committed NBAS to adding additional specificity to its recommendations, and this has been born out in the implementation of the second NBAS.

The current NBAS has been constituted this year under six workgroups that are more closely aligned with the "National Biosurveillance Strategy for Human Health," with the exception of the Governance Workgroup, which is aligned with the recommendation of the NBAS and was called out in the "National Biosurveillance Strategy for Human Health" as an important need. Drs. Delbanco and Mandl, as members of ACD, are represented on NBAS. The NBAS members by workgroup are as follows, with federal liaisons shown at the bottom of the matrix:

NBAS Membership Matrix

NBAS Members by Task Force					
<small>Governance, Inter- Agency, Collaboration and Engagement</small>	<small>Healthcare & Public Health Information Exchange</small>	<small>Innovative Information Sources</small>	<small>Global and Regional Bio-surveillance collaboration</small>	<small>Bio-surveillance Workforce, needs, education, skills training</small>	<small>Interagency Multi-Sector Information</small>
CHAMPION	CHAMPION	CHAMPION	CHAMPION	CHAMPION	CHAMPION
Robert Kadlec	Steve Hottel	Ian Lipkin	Jim Hughes	Don Burke	Lionie King
MEMBERS	MEMBERS	MEMBERS	MEMBERS	MEMBERS	MEMBERS
Tom Inglesby	Cecil Lynch	James Heywood	Jim LeDuc	Jim Hadler	Heather Case
Paul Jarriss	Julia Gunn	Rita Colwell	David Franz	Linda McCausley	Richard Platt
Perry Smith	Suzanne Delbanco	Ron Brookmeyer	Ann Marie Kimball	Tomas Aragon	Art Reingold
Larry Bennett	Ken Mandl		Mary Wilson	Kathy Miner	Al Bronstein
Marc Layton			Stephen Oseroff		
Federal Liaisons					
<small>1. Dr. Pamela Diaz - Centers for Disease Control and Prevention (DFO) 2. Raul Sotomayor - U.S. Department of Health and Human Services 3. CPT Kevin Russell - U.S. Department of Defense 4. CDR David Brazas - U.S. Department of Defense 5. COL Robert DeFuria - U.S. Department of Defense 6. Jessica Putz - U.S. Department of Agriculture, Office of Homeland Security and Emergency Coordination 7. Dr. Randall Riccardi - U.S. Department of Defense, Defense Threat Reduction Agency 8. Dr. Michael Kurilla - U.S. Department of Health and Human Services - CMMI, NIAID, NIH, Office of BioDefense Research Affairs 9. Dr. Teresa Dominguez - U.S. Department of Homeland Security 10. Dr. David Lipman - U.S. Department of Health and Human Services - National Institute of Health 11. Dr. Cynthia Lucero - U.S. Department of Veterans Affairs</small>					

The second NBAS report is scheduled to be submitted to the ACD during the April 2011 meeting. The task forces are working diligently to complete their reports and submit them to the NBAS co-chairs by February 1, 2011.

2010 / Future Activities

Jeffrey Engel, MD
State Health Director for North Carolina
Co-Chair, National Biosurveillance Advisory Subcommittee

Dr. Engel first presented on the activities of NBAS over the past year. As Dr. Diaz noted, last year's report was a high level focus. In accordance with Dr. Frieden's emphasis on thought to action, this year's report is anticipated to include more concrete recommendations for biosurveillance. A significant amount of work was done in preparation for the first report, and the workgroups are building upon those efforts. For the second report, the workgroups will be tracking more closely to National Biosurveillance for Human Health Priority areas. Although NBAS members are purposely outsiders of the federal government, they represent a wide range of state governments, non-governmental perspectives, and academia and they are working closely with federal liaison partners to stay aware of current government activities in biosurveillance and understand policy directions.

Much of the research being pursued has overlaps (e.g., workforce needs, health care and public health information exchange, et cetera). Coordination and joint briefings have occurred on an on-going basis among NBAS's members to facilitate that work. Most of the workgroups have been very active in requesting documents and briefings relevant to the subjects they are pursuing. A template was provided to help guide the individual task forces toward a common format. Once the individual workgroup's reports are received, NBAS members, including the steering committee workgroup, will then utilize those reports to develop a final report that prioritizes important initiatives, focuses on a short list of the most important issues to address, and takes note of secondary and tertiary issues. The result will adhere to NBAS's goal of making this year's report / recommendations more specific.

Dr. Sanchez praised NBAS for how quickly a charge from the White House was turned into a spectacular report, and thanked all who were involved in this effort.

Surveillance and Epidemiology Workgroup Update and Discussion

Kelly J. Henning, MD
Director, International Health Program
Bloomberg Foundation
New York, New York

Dr. Henning explained that this presentation would focus considerably on the Surveillance and Epidemiology Workgroup's PPACA discussions, and how they feed into the larger conversation that they had been having throughout the day. She indicated that she is currently the only ACD member on the Surveillance and Epidemiology Workgroup, and invited others who were interested to join. This workgroup currently consists of the following membership:

- Kelly J. Henning, MD, Chair (Director, Public Health Programs, Bloomberg Philanthropies)
- Melinda Buntin, PhD (Director, Office of Economic Analysis and Modeling, ONC, DHHS)
- Jac J. Davies, MS, MPH (Director of INHS Center for Innovation and Quality, Director of Beacon Community of the Inland Northwest)
- Paul Halverson, DrPH (State Health Officer, Arkansas)
- Sara L. Huston, PhD (Chronic Disease Epidemiologist Maine Center for Disease Control and Prevention)
- Thomas E. Kottke, MD, MSPH (Medical Director for Evidence-Based Health, HealthPartners Research Foundation)
- Jeffrey Levi, PhD (Executive Director, Trust for America's Health)
- Kimberly Rask, MD, PhD (Director, Emory Center on Health Outcomes and Quality)
- Steven Teutsch, MD, MPH (Chief Science Officer, Los Angeles County Public Health)
- Lorna Thorpe, PhD (Director, Epidemiology and Surveillance Program, City University of New York School of Public Health)

These members all participated in the first conference call in late September 2010. Given that this workgroup had not yet met in person, they were provided with a significant amount of background materials that were the subject of that call.

With the input of the Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), the workgroup has come together to address one particular issue in the beginning. This is expected to evolve over time, and there may well be other items that will be brought to the workgroup from OSELS. The members are prepared to continue to interact with OSELS to determine potential future activities.

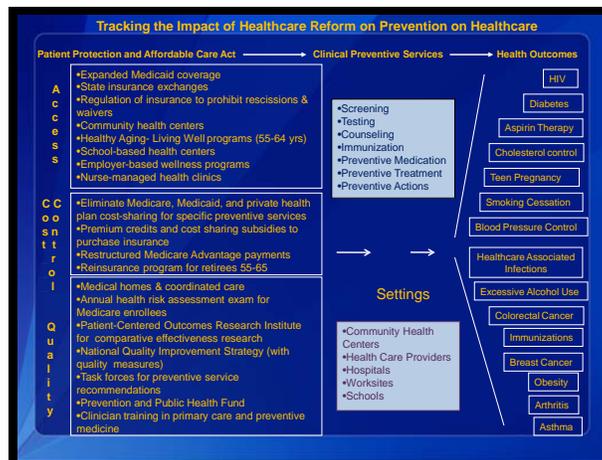
One of the first tasks delegated to the Surveillance and Epidemiology Workgroup was to provide support to OSELS as it relates to their work in assessing surveillance opportunities regarding PPACA. This activity relates to a charge from Dr. Frieden to create a Surveillance Report on "Tracking the Impact of Healthcare Reform on Prevention in Healthcare." While OSELS is coordinating this effort, it draws upon the work of subject experts in multiple parts of CDC, particularly the National Center for Chronic Disease Prevention and Health Promotion. As outlined in the invitation letters to each of the workgroup members, there are particular

questions that CDC would like this workgroup to have in mind in working through this first assignment, including the following:

- What indicators are most appropriate for CDC to track to evaluate the impact of the PPACA?
- What data sources, both health care service-based and population-based, would be most appropriate for tracking these indicators?
- To what extent can we assume that observed changes in the health care system are related to PPACA versus other efforts that might have similar effects, such as affordability, access, or quality of care services?
- To what extent can trends in health care services and trends in health status be linked or associated?
- How can we monitor state-specific PPACA-associated changes in health care services?
- How do CDC surveillance efforts pertaining to PPACA interface with / complement other monitoring efforts related to accountability under PPACA that are in place in other agencies?

As a starting point, they decided to organize around the ABC's for prevention of cardiovascular disease and stroke (Appropriate **A**spirin use, **B**lood pressure and **C**holesterol control, and **S**moking prevention and cessation), as well as CDC's winnable battles (HAIs; HIV Prevention; Motor Vehicle Injury Prevention; Obesity, Nutrition, Physical Activity and Food Safety; Teen Pregnancy Prevention; and Tobacco).

The workgroup's organizing framework is reflected in the following illustration:



On the far left are the areas of access, cost control, and quality that are imbedded in the PPACA. The workgroup is highly cognizant of the fact that there are a number of other activities underway that pertain to PPACA. Thus, the workgroup is monitoring other indicator activities to ensure that efforts are not duplicated, including: HP2020, HEDIS, National Healthcare Quality Report (AHRQ), State of USA Indicators, HHS Health Indicators Warehouse (NCHS), HHS ACA Measurement and Evaluation Workgroup Dashboards, and others). The number of indicators that these represent is amazing. For example, HP2020 includes 467 objectives for 2010 using 199 data sources and 28 focus areas. The State of the US indicators includes 20 key health

indicators. The take-home message is that creating a new set of indicators to conduct this surveillance work is going to require considerable assessment of other indicators.

A comprehensive indicator list was developed by OSELS that was distributed to the workgroup. Samples from the 60 total indicators are as follows:

- Percentage of women aged 55 to 79 years and men aged 45 to 79 years who have been counseled about the risk and benefits of ASA therapy
- Proportion of adults who undergo BMI assessment at routine check ups
- Increased tobacco screening in hospital ambulatory care settings
- Percentage of patients > 18 years who have had a stroke who have their LDL at or below the recommended level (< 100mg/dl)

Feedback was obtained from workgroup members about these indicators. The workgroup felt that in some cases, there was a confusing mix of health outcomes and process indicators, and that it would be important in the next iteration to identify standard criteria for deciding what belongs. Concern was also expressed that no immunization indicators were included. Members felt that health outcomes and the indicators must be tied concretely to PPACA. They also pointed out that evidence was missing for some of the preventive services. Many data sources and collections are occurring to assess the PPACA, so the workgroup members felt that it was important to clearly articulate how CDC's work differs. Members wondered what actions would be suggested as a result of these surveillance findings, and suggested that CDC's role in seeking to affect the availability and delivery of preventive healthcare services should be clearly defined. The workgroup also felt that the list of indicators should be shortened dramatically.

OSELS has taken this feedback to heart and is currently refocusing their efforts. To that end, they are assessing CDC priority health outcomes, which may or may not fall entirely within the winnable battles. They are also assessing primary and secondary prevention services that are likely to be affected by PPACA such as specific services that must be covered without cost sharing, and general effects on other preventive services that will potentially be affected by increases in insurance coverage. Also being considered are population health measures (e.g., persons or patients are the focus of the measurement not payers or providers). In addition, OSELS is assessing the data sources that are available for reporting on a regular basis. There are also plans to document the proportion of the population receiving recommended prevention services or who have their condition under control. In terms of "data to action," OSELS plans to identify needs and disparities; educate / raise awareness among the population about recommended prevention services; support increased utilization of preventive services; support reduction in out-of-pocket costs for preventive services; support community and clinical preventive services guideline development; and increase adherence to clinical guidelines.

With regard to next steps, OSELS is reviewing PPACA for additional preventive services that should be considered for the surveillance report; finalizing the list of indicators with input from workgroup; working with programs to implement the indicators (define numerators and denominators); creating a timeline for data analyses and writing; will be conducting data analyses; and will be begin drafting the surveillance report. The ultimate goal is to publish the surveillance summary report in a Spring 2011 *Morbidity and Mortality Weekly Report (MMWR)*.

Discussion Points

- Dr. Sanchez indicated that he and Dr. Fleming serve on the National Commission on Prevention Priorities (NCP), which has assessed a subset of the USPSTF recommendations, primarily those that are universally applicable to large populations. In addition, NCP has examined utilization of those *Clinical Preventive Services* with some racial / ethnicity breakdowns. While that report is about two years old, it may serve as a baseline to determine what progress has been made. NCP is supported with a cooperative agreement from CDC, so there is an established relationship. NCP is also considering how to engage in a similar process with regard to the *Community Guide*. PPACA specifically mentions both the *Clinical Preventive Services* and the *Community Guide*. It would be beneficial to show improvement as Dr. Chu did in his report on Kaiser Permanente.
- Dr. Fleming inquired as to whether specific consideration was given to preventive services during pregnancy and birth outcomes as indicators. For example, it is important to demonstrate some short-term success such as the immediate returns possible from tobacco cessation during pregnancy.
- Dr. Henning replied that there was an indicator for teen pregnancy, but she did not recall any particular pregnancy indicators beyond that.
- Dr. Delbanco added that in prenatal care, there are not many indicators that have a very strong evidence base.
- Dr. Frieden reported that some jurisdictions have worked with the Medicaid managed care plan. This is the one area that plans are willing to work on because all they have to do is prevent one neonatal ICU stay and that pays for the program for the next 10 years.
- Dr. Sanchez added that the private side has also come to realize that there is tremendous investment in programs that steer and incentivize doctors to get women into prenatal care programs because this can be cost saving on many levels (e.g., reduced caesarian section rates, better birth weights, shorter neonatal stays, lesser workplace productivity loss for mother / spouse / employer). Unintended pregnancy is already one of the winnable battles.
- Ms. Kelly believes that for private sector employer paid programs, this is one of the top claims that is approved because the potential costs / savings are well-recognized.
- Dr. Frieden highlighted the importance of addressing the gap for approval with no co-pay. Some jurisdictions are using web delivery. He wondered, for example, if someone indicated that they wanted to quit smoking whether Kaiser Permanente would say, "Click here and we will send you a box of patches."
- Ms. Kelly replied that many of these types of service deliveries occur in the workplace (e.g., patches are delivered to the workplace, women are given time off for prenatal care appointments, et cetera).
- Dr. Sanchez added that the NCP framework lumps some of the preventive services as cost savings, minimally costly, and somewhat more costly.
- Dr. Botchwey wondered about populations that might be missed in data reporting, and whether the workgroup had any discussions about this.

- Dr. Henning responded that the idea was to use existing data sets and surveillance mechanisms; thus, they are not talking about setting up additional or new surveillance programs at this point. The extent to which BRFSS, National Health and Nutrition Examination Survey (NHANES), and other systems are available and do / do not capture risk populations is potentially an issue. The workgroup discussed this to some extent when they began to assess the potentially available data.
- With regard to the PPHF, Dr. Frieden indicated that PPACA includes \$750 million for prevention this fiscal year. Last fiscal year \$500 million per year was included. This fund will increase to \$2 billion per year. At last count, about a half a dozen attempts have been made to zero the funds out in Congress. It has strong supporters. The House and Senate versions of the bill differed. The Senate version (and from CDC's perspective) envisions dividing this into three buckets: 1) more / better information; 2) public health infrastructure; and 3) addressing leading causes of illness and death through mechanisms such as community transformation grants. In the first bucket, CDC received resources in the last fiscal year to strengthen healthcare surveillance. Perhaps a very useful function of the workgroup would be to assess this effort. One of the activities is the conduct of a National Ambulatory Medical Care Survey that has some possible inserts of the Medical Care Survey. Both have cohorts of physicians who have been retiring, but who are not being replaced. The plan is to refresh those cohorts and make the survey electronic.
- Dr. Henning thought the workgroup members would like to take on this task.
- An inquiry was posed regarding where there would be an opportunity because of PPACA to be in a better position to make use of electronic medical records, and within that to support connections to public health as that capacity grows, particularly with public health being on the receiving end.
- Mr. Rein added that while resources are tight, there may be resources available to address specific disparities and disabilities. There are also regional and timing issues.
- Dr. Frieden indicated that there are some best practices within CDC, including the National Health Injury Survey (NHIS), which releases data on a quarterly basis. There is also policy surveillance, as well as the *Community Guide*. One effort that has been discussed is for Dr. Monroe's office and Dr. Thacker's office to assess how many of the recommendations in the *Community Guide* that have the greatest impact are actually being implemented in each state. Adoption of evidence-based policy is another form of surveillance.
- Dr. Sanchez pointed out that a number of people have recognized that data are not as granular as they should be with regard to disparities. Lovell Jones, Director of the National Health Disparities Center in Houston, Texas has pointed out that according to some specific data in the Houston area, African American's incidence of breast cancer is actually higher than it is among whites, which is not the current conventional wisdom. His point was there may be value in assessing some datasets in particular parts of the country. California's Health Interview Survey is very rich and can be drilled down to sublevels of race / ethnicity. This could inform better federal surveillance. He thinks that even PPACA under-

appreciates the value of monitoring and surveillance, so this is an opportunity for CDC to compile information beyond systems such as HEDIS that are about demonstrating the return on investment.

Establishing a Communications Workgroup

Donna Garland, BA Associate Director for Communication

Ms. Garland reminded everyone that the importance of communication and the need for robust communication activity at the agency level was raised as an issue during the April 2010 ACD meeting. Given that a number of members endorsed the establishment of an ACD Communications Workgroup during that meeting, the October 2010 ACD agenda included an official proposal to stand up such a group. Ms. Garland explained that CDC had a Board of Scientific Counselors (BSC) for the National Center for Health Marketing from 2007 to 2010. The purpose of the BSC was to advise the HHS Secretary and CDC Director concerning strategies and goals for programs and research; peer-reviews scientific programs; and monitor strategic direction and focus. The BSC was also charged to perform second-level peer review of applications for grants-in-aid for research and research training activities, cooperative agreements, and research contract proposals. The BSC was recently disbanded.

The Federal Advisory Committee Act (FACA) defines a “workgroup” as two or more advisory committee or subcommittee members convened solely to gather information or conduct research, to analyze relevant issues and facts, or to draft proposed position papers for deliberation by the advisory committee or subcommittee of the advisory committee. A workgroup should be used to research and provide input on a narrow question, or to address an issue on a short-term basis. Formation of a Communication Workgroup of the ACD is an opportunity to provide specific, actionable guidance on key health communication issues. Immediate issues / focus areas include, but are not limited to:

1. Identify areas for basic research as well as research on knowledge transfer
2. Establish focused, clear messages that are of value to target audiences
3. Develop a core set of metrics and evaluation practices to measure the impact of CDC’s communication activities (such as new and social media communication) that are most relevant to agency priorities
4. Identify or develop recommended “best” or “promising” practices for health communication
5. Identify capacity needs in the area of internet and social media
6. Identify high-potential media for future health communication focus
7. Respond to and evaluate specific health communication strategies and plans

The new CDC Office of the Associate Director for Communication (OADC), Ms. Garland’s office, is focused on communication research, practice, production, and evaluation. As such, the OADC staff would serve as the principal liaison with the ACD Communication Workgroup. Some of the challenges that she has put forth to the OADC staff is that they absolutely must continue to be thoughtful leaders in communication; assess research, practice, and the state of practice at the agency in terms of public health; and set targets, evaluate, and promulgate the

practice of communication in the public health realm. The following suggestions were made by ACD members and others present prior to the motion and vote:

- Reflecting on Dr. Frieden’s earlier comments about prevention and the “Make It Happen Make It Known” campaign, add a focus area to market health:
 - Benchmark other organizations’ changes and follow others who are testing out a radical re-configuration in how they communicate, but be cautious, given that *radical* is suspect in public health
 - CDC is already a leader in many social marketing communication activities
 - Do not forget traditional media such as television and radio, which are still very important in terms of how many people hear about what is happening
 - Remember that not all communications have to be media-related
 - Viral YouTube videos can reach millions, as can messages in television shows
 - Seek advocates to communicate public health messages at no cost
 - Combine communication messages (e.g., pool sinks, water bottles, and physical tools to promote health such as a neat straw that lets the water swirl around before it goes into someone’s mouth, and then use the process for a can of soda)
 - Craft straightforward messages
- Consider including traditional and non-traditional workgroup members to expand perspectives and challenge pre-conceived notions; suggested members to recruit:
 - Corporate representatives
 - Advertising professionals
 - Media representatives
 - Community advocates
 - Grassroots entities
 - Industry representatives
 - Television and movie industry professionals
- A unique, endearing, but unfortunate characteristic / challenge of public health is that the better public health does, the less people notice it (e.g., the dog not barking in the night, the epidemic that does not occur, and the outbreak that is stopped before it spreads)
- Personalize issues; existing examples that align with the winnable battles include:
 - A public service announcement of a woman whose unvaccinated child died of influenza
 - Ads from throughout the world of people telling stories about what tobacco did to their lives and their physician who says, “I know because I have taken care of people who have had miserable, horrible lives and deaths from tobacco”
 - Ads with positive images of a family, spouse, or a child who is grateful for someone stopping smoking

- Perhaps once a month there should be a good public health message to personalize public health issues that goes viral
- Remember that community and attitude are important (e.g., how people lead their lives), as is the language of a holistic focus on health; this includes prevention
- While delivering a communication message is important, infrastructure must be in place to allow that message to deliver an achievable objective (e.g., ensure that the hand washing message to prevent healthcare-acquired infections is actually executed)
- Use existing models in order to increase reach, build trust, and better utilize funding resources:
 - The Media, Access, Point of Purchase / Promotion, Pricing, and Social Support and Services (MAPPS) framework
 - Lessons learned by states and local health departments regarding how to leverage resources and get messages out
 - The full repository of wisdom within CDC in terms of addressing the role of government (In his classic essay, *Reflections on the Revolution in France*, Edmund Burke said, “Government is a contrivance of human wisdom to provide for human wants. Men have a right that these wants should be provided for by this wisdom”); it should not take a quote from an Irishman 220 years ago to realize that CDC’s repository of wisdom can be applied to human wants
 - Dr. Bal’s work in California

Motion: Establish a Communications Workgroup

Dr. Bal made a motion to create a Communications Workgroup, utilizing Tab 9 as the framework to establish this workgroup and understanding that the list of “Immediate issues / focus areas” is not limited to the 7 items currently listed. Dr. Wheeler seconded the motion. The motion carried unanimously.

Following the vote, it was suggested that Drs. Climan and Delbanco serve as the two ACD Workgroup members required on the Communications Workgroup. Drs. Delbanco and Climan indicated that they would have to give up their positions on their other ACD Workgroup if they were assigned to the Communication Workgroup. A final decision was not made at this time; however, Dr. Sanchez assured Dr. Frieden that two members would ultimately be confirmed. Dr. Bal suggested the inclusion of Paul Kai, an advertisement professional from the private sector.

Public Comment

No public comments were offered during this session.

Wrap-Up and Closing

Discussion

Dr. Sanchez concluded that the meeting had been highly productive, and summarized the following take-home messages:

- CDC has significant opportunities to further explore, nurture, and grow its global health efforts
- Policy was addressed in the context of informing the health of America in a post-PPACA environment
- Given that ethics issues have moved beyond communicable diseases, PHEC was charged to address non-communicable diseases as well
- The STLT Work Group was charged to enhance STLT capacity nationwide, territory-wide, and otherwise
- NBAS offered an excellent update on national biosurveillance efforts
- With respect to surveillance and monitoring, thinking toward the future, it is important for the agency to demonstrate progress and substantiate the value that CDC adds to these activities
- A Communications Work Group was established

Dr. Sanchez thanked all of the staff members who assisted everyone with logistics, particularly given the inclement weather the previous day, and expressed appreciation for the opportunity to participate with CDC in the important goals of the ACD.

Dr. Frieden expressed his gratitude for everyone's time, participation, and contributions. He emphasized the importance of being able to share some of the agency's challenges (e.g., efforts to address the public health clinical medicine interaction; standing up the CGH effectively and putting it on a sustainable and solid footing; policy issues that surround everything; elevating the importance of prevention, et cetera) and to acquire feedback and support with respect to how to address these challenges. In speaking with a Congressional staffer recently, he said he thought prevention had bipartisan support, to which the staffer responded, "Yes, the prevention has bipartisan support. Funding for prevention does not." He stressed the importance of making prevention known and building the base for prevention so that funding is allocated where it really needs to be and disease is being prevented. As the nation's prevention agency, Dr. Frieden concluded that CDC has an important role to play and accentuated the importance of the ACD to the agency in that role.

With no further business posed or questions / comments raised, the meeting was officially adjourned.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 28, 2010 meeting of the Advisory Committee to the Director, CDC are accurate and complete.

Date

Eduardo J. Sanchez, MD, MPH, FAAFP
Chair, Advisory Committee to the Director
Centers for Disease Control and Prevention

Appendix #1: Attendance Roster

ACD Members

James Nicholson (Nick), Baird, Jr., MD (via telephone)

CEO, Alliance to Make US Healthiest and
President, Stillwater Solutions, LLC

Dileep G. Bal, MD, MS, MPH

Kauai District Health Officer
Island of Kauai, Hawaii

Vivian Berryhill

President and Founder
National Coalition of Pastors' Spouses

Nisha D. Botchwey, PhD

Associate Professor of Urban and Environmental Planning and
Public Health Sciences, School of Architecture, University of Virginia

Sanford R. Climan, MBA, MS

President, Entertainment Media Ventures

Suzanne Frances Delbanco, PhD

Executive Director
Catalyst for Payment Reform

David W. Fleming, MD

Director and Health Officer for Public Health
Seattle and King County

Alan E. Greenberg, MD, MPH

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Kelly J. Henning, MD

Director, International Health Programs
Bloomberg Foundation

Mary Kelly

Executive Vice President
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Shoppers Drug Mart

Jonathan T. Lord, MD (via telephone)

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Harold and Jane Hirsh Professor of Health Law and Policy and Chair
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Eduardo J. Sanchez, MD, MPH, FAAFP

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Blue Cross and Blue Shield of Texas

John R. Seffrin, PhD

Chief Executive Officer
American Cancer Society

M. Cass Wheeler

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

Chairs of Subcommittees**Jeffrey Engel, MD (via telephone)**

State Health Director for North Carolina
Chair, National Biosurveillance Advisory Subcommittee

Robert L. Hood, PhD

State Public Health Ethicist, Florida Department of Health
Chair, Ethics Subcommittee

Special Guests**Benjamin K. Chu, MD, MPH, MACD**

President, Southern California Region
Kaiser Foundation Health Plan, Incorporated, and Hospitals

Sylvia Drew Ivie, JD

Chief of Staff, Los Angeles County Government

Centers for Disease Control and Prevention**Ileana Arias, PhD**

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

Lynn Austin, PhD

Deputy Director
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Drue Barrett, PhD

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Office of the Director, CDC
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