



Minutes from the April 28, 2011

CDC Advisory Committee to the Director

***Release Date
July / 2011***



Advisory Committee to the Director: Record of the April 28, 2011 Meeting

Table of Contents

Advisory Committee to the Director Record of the April 28, 2011 Meeting.....	3
Call to Order, Welcome, and Introductions.....	3
Ethics Subcommittee Report: Ethical Considerations for Non-Communicable Disease Interventions	3
Ethics Subcommittee Report: Ethical Considerations for Decision-Making Regarding Allocation of Mechanical Ventilators During a Severe Influenza Pandemic or Other Public Health Emergency	7
National Biosurveillance Advisory Subcommittee Final Report: “Improving the Nation’s Ability to Detect and Respond to 21st Century Health Threats: Second Report of the National Biosurveillance Advisory Subcommittee”	8
State, Tribal, Local, and Territorial (STLT) Workgroup: Directional Recommendations for Enhancing CDC Support to STLT Community	9
Global Workgroup (GWG) Update.....	14
Public Comments	14
Closing Remarks.....	14
Certification	16
Attachment #1: Attendance	17
Attachment #2: Acronyms Used in This Document.....	24



**Advisory Committee to the Director
Record of the April 28, 2011 Meeting**

The Centers for Disease Control and Prevention (CDC) convened a meeting of its Advisory Committee to the Director on April 28, 2011. The agenda included reports from the Ethics Subcommittee; the National Biosurveillance Advisory Subcommittee (NBAS); State, Tribal, Local, and Territorial (STLT) Workgroup; and the Global Workgroup (GWG).

Call to Order, Welcome, and Introductions

Dr. Eduardo Sanchez, ACD Chair, called the meeting of the Advisory Committee to the Director (ACD), Centers for Disease Control and Prevention (CDC), to order at 1:06 pm. A quorum of 18 ACD members was present on the call. Dr. Sanchez recognized that a number of other staff members from CDC and CDC Foundation were present on the call.

Dr. Sanchez welcomed four new members to the ACD: Sylvia Drew Ivie, JD, and Dr. Benjamin Chu, who spoke at the October 2010 ACD meeting; and Dr. George Isham and Dr. Anthony Iton. Dr. Sanchez emphasized that the ACD ordinarily meets in person and has time to work through issues, and that telephone meetings are the exception rather than the custom.

The following conflicts of interest were indicated by ACD members:

- Dr. Alan Greenberg disclosed that his department receives indirect funding from CDC on three projects: DC Department of Health, Elizabeth Glazer Pediatric AIDS Foundation, and Association of Public Health Laboratories.
- Dr. Sara Rosenbaum disclosed that her department in health policy receives at least one CDC grant that focuses on sexually transmitted diseases, health policy, and Patient Protection and Affordable Care Act (PPACA).

**Ethics Subcommittee Report:
Ethical Considerations for Non-Communicable Disease Interventions**

Dr. Sanchez introduced Ruth Gaare Bernheim, Chair of the Ethics Subcommittee. He explained that during the ACD's meeting in October 2010, there was discussion of ethical considerations for non-communicable disease (NCD) interventions. The Ethics Subcommittee was asked to create a framework around these issues.

Ms. Bernheim thanked the ACD for the opportunity to present and acknowledged the input of the two ACD representatives on the Ethics Subcommittee, Cass Wheeler, and Sara Rosenbaum. She explained that the central question regarding the ethics of non-communicable disease interventions is, *"How can we address ethical tensions that arise when public health intends to implement restrictive or regressive policies and approaches that focus on chronic diseases and injuries rather than infectious diseases?"*

The ethics of NCD interventions raises specific questions:



Advisory Committee to the Director: Record of the April 28, 2011 Meeting

- ❑ When is it appropriate or acceptable for public health to limit individual choice, either directly, such as by requiring use of helmets or prohibiting use of food vouchers for soft drinks, or indirectly, such as increasing taxes on cigarettes?
- ❑ What are the ethical considerations that need to be thought through in these situations?
- ❑ How do we best facilitate the adoption of public health interventions for NCDs?

The Ethics Subcommittee discussed a strategy for addressing the central question. They further discussed how to expedite the translation of scientific knowledge into implementation of interventions that protect the public, prevent disease and injury, and promote health. The gap between knowledge and implementation is an important area of focus for policy makers and public health officials. In this gap, it is critical to have information about values and norms, as well as the competing claims of various stakeholders.

While population health impact, based on science and data, is the preeminent value animating public health, moving from science to implementation involves collective action and acceptance by the public. Given the religious and moral pluralism in society, it is inevitable that ethical tensions arise in public health that cannot be resolved without some controversy and without policy justifications in the “gap” between science and implementation. Therefore, implementation of effective programs and policies requires understanding the competing moral claims of various stakeholders, and developing counter claims and policy rationales that resonate ethically with the public at any given time.

The story of tobacco control illustrates this point. Public health justifications countered early claims of paternalism that were mounted against tobacco restrictions by focusing on third party harms, youth onset, and the addictive quality of tobacco. These counter ethical arguments garnered support for grassroots initiatives at the local and state levels. The various initiatives (e.g., smoking bans in restaurants, point-of-sale restrictions, and anti-tobacco curricula in schools) were ethically acceptable in particular communities at different times across the country. Understanding context matters in the gap. Local and state successes in the gap helped foster larger shifts in social norms and generated the political will necessary for stronger and more restrictive tobacco control measures. State and local health departments have expressed strong interest in more ethics training and guidance. With regard to NCD issues, the goal is to use a combination of interventions that are least restrictive and most empowering of individuals. They may begin with interventions that focus on information and non-coercive nudges so that over time, social norms are changed without the need for sanctions and enforcement.

Ethical analysis in public health provides information about stakeholder values, norms, and ethical tensions. This analysis is parallel to legal consultation in that it provides a systematic way to understand, balance, and address competing claims, and provides a method for developing policy justification or rationales. For example, perhaps a proposed tax, such as a much higher tax on tobacco products, is likely to disproportionately affect vulnerable and poor populations. Upon analysis, the tax may be justifiable: 1) If the revenues generated from that tax are used only for programs for the poor; 2) If there is evidence that those programs are likely to be successful in lowering tobacco use among



that group; and 3) If it is shown that they are necessary to address disparities in tobacco use and get to the next stage of this Winnable Battle.

The Ethics Subcommittee considered various levels of public health interventions and examined how the mandate for government action and the tensions created by competing stakeholder claims vary for different intervention content areas. One example is a classic case that state and local health departments face regularly: interventions for preventing the transmission of infectious diseases, such as tuberculosis (TB). These interventions typically involve restricting individual liberty by placing restrictions on movement in the name of protecting the public good. These types of interventions are generally well-accepted by the public and are believed to be justifiable when there is a risk of direct harm to others. Factors that influence acceptability are severity, probability, and the imminence of risk or harms. These types of interventions show that alignment of the public with government authority is strongest when members of the public fear imminent harm and / or risk of infectious disease for themselves or their families.

Another example involves the use of sanctions and enforcement for injury prevention, such as legislation requiring airbags in cars, use of seatbelts, and motorcycle helmets. These types of interventions often focus on product regulation and making it safer to use vehicles. Product regulation and the safe use of products is widely accepted by the public as within government's appropriate domain; however, these regulations were initially perceived by some as coercive government intervention that limited individual liberty. Framing these interventions as ways to avoid or reduce social costs to others and as the best way to make products and the environment safer for individuals has led to greater acceptance of these types of interventions.

An additional example focuses on interventions for chronic disease prevention that involve use of incentives and nudges. In the prevention of cardiovascular disease and lung cancer, the use of coercive interventions that override individual liberty, such as limiting tobacco use, was initially not widely accepted to be within the government's purview. This case is instructive because despite having overwhelming scientific evidence concerning tobacco's danger to health, it required decades of activities in the gap addressing stakeholder claims and values to begin making a case for stronger tobacco regulation.

It is useful to compare the public values pertaining to the proposed soda tax and cigarette tax. Both of these interventions are seen by some as regressive in that the burden falls most heavily on those with less disposable income. The health effects of both products are proportional to use. Health effects of moderate consumption of sugared beverages are less clear, however, as soda is not an inherently dangerous product that directly leads to increased disease risk. Further, the relationship between cigarette use and indirect harms to others is clear, whereas the impact of soda use on others is unclear. From a public health ethics perspective, neither of these taxes addresses the root cause of the role of manufacturers in producing and marketing unhealthy products.

It is clear that the context of the public's view of the use of governmental public health authority to override individual liberty changes along the spectrum from government protection to prevention and promotion. It is also clear that in chronic disease prevention, some public resistance focuses on the appropriateness of government's role. Some perceive these types of government interventions as unnecessary because there is no imminent risk of grave harm. These interventions are also sometimes perceived as



unjustified intrusions into individual liberty and a “slippery slope” to the “nanny paternalistic state.”

Approaches to chronic disease are especially challenging because they often involve behavior change in the population, which can also lead to claims about a “nanny government.” Unlike infectious disease control, where there is more support for government authority, judicious use of government authority is key in NCD issues. For example, policies that shift default conditions in the environment to make it easier for individuals to choose healthier food options are powerful tools, partially because this use of authority is ethically supported in that the policies support individual choices and enhance personal freedoms. Thus, in chronic disease, it is important to counter claims of paternalism and “nanny government” by demonstrating support for individual responsibility and enhanced consumer choice. It is also important to remember that changing social norms and behavior is a gradual process. There are advantages to working with coalitions and in collaboration with stakeholder groups, including affected industries. Legal intervention or policy may be helpful, and should be within already-accepted government mandates whenever possible. Even the declarative effect of some laws can assist with the gradual change of social norms, as with seat belt laws.

The Ethics Subcommittee felt that ethical frameworks and precedent cases could be helpful in developing interventions in a gradual sequence, taking into account evolving social values, unintended consequences, and the policy rationales in the public arena. Health equity is also an important ethical concern. The tools of tobacco control, for instance, have been relatively ineffective in reaching lower socioeconomic groups. For example, some tobacco control interventions have a disproportionate effect on the poor who can least afford to pay higher tobacco taxes.

To achieve implementation and best outcomes, CDC must not only gather surveillance data and provide scientific evidence about health impact and effectiveness of interventions, but also should gather information about this area of the gap between knowledge and implementation. To do that, public health officials need information about ways to address ethical tensions in the gap creatively, with counterarguments based in science or with imaginative policy justifications based on ethical considerations or principles, to facilitate implementation. Science and data are the foundation of public health and are critically necessary, but may not be sufficient to win the battles involving competing moral claims in the gap.

Discussion Points

- Dr. Sanchez thanked Ms. Bernheim and acknowledged Dr. Drue Barrett, the Designated Federal Officer (DFO) for the Ethics Subcommittee. He commented that the presentation provides a beginning of a framework for thinking about the translation of scientific knowledge into policy and practice. He felt that CDC leadership should have time to review the presentation in order to assess how the Ethics Subcommittee might best provide further input. There is a desire among those who engage in public health work for this information to address the ethical tensions in that gap. The Ethics Subcommittee is developing case studies, and the examples provided in the presentation peaked his interest. The development of the cases may be useful in helping people think through the challenges they encounter in their work.
- Dileep G. Bal, MD, MS, MPH, District Health Officer, Island of Kauai, Hawaii, thought the presentation was fascinating and comprehensive. However, he expressed his



hope that the presentation did not imply that any interventions should slow down pending what could be an extended and drawn-out review of these ethical considerations. Further, he hoped that the presentation would not have the reverse effect of its intent. In recent years, the translation of scientific evidence to policy has been hampered by various elements, including social context. If ethical consideration issues are introduced as a major level of litmus test, it may do a disservice to the process. He was thinking specifically of obesity in this instance. While he observed that the presentation was thoughtful and balanced, Dr. Bal was concerned that it may give naysayers in industry evidence to call for more science and to ask for a slowdown in interventions.

- Ms. Bernheim replied that their goal is the opposite of slowing things down. The intent is to address barriers in the gap area that slow the process from science to implementation. In particular, competing moral claims in the gap should be addressed. Addressing the barriers will speed movement from science to implementation. Barriers can include scientific information that is not well-understood, as well as stakeholder moral claims that are introduced by those who want to slow movement to policy.
- Carmen Villar, MSW, Chief of Staff, CDC, DFO for the ACD, clarified that the presentation did not need to be accepted formally by the Committee. The presentation will be shared with senior CDC staff for further discussion.

Ethics Subcommittee Report:

Ethical Considerations for Decision-Making Regarding Allocation of Mechanical Ventilators During a Severe Influenza Pandemic or Other Public Health Emergency

Ms. Bernheim reminded the group that the Ventilator Document provides an overview of ethical points to consider for the allocation of ventilators during a severe influenza pandemic when the number of people requiring ventilation outnumbers the available supply of ventilators. The document is intended to supplement a previous document written by the Ethics Subcommittee, "Ethical Guidelines in Pandemic Influenza," which was released in 2007. This document focused on the allocation of vaccines and antivirals and the use of interventions to create social distancing.

Since the ACD last reviewed this document in April 2010, comments were solicited from a variety of public health, healthcare, and emergency management professionals, including hospital directors, administrators, physicians, and risk managers; hospital associations; professional medical associations; state health department officials; regional emergency coordinators; non-profit organizations; and private physicians and community / patient advocates. The comments pointed to the importance of having ethics input on ventilator allocation decisions and raised a number of issues relating to implementation details; the needs of infants and children; the triage process and details about the triage team; uniformity of decision making versus local flexibility; and the importance of public engagement.

The primary revisions to the document involved adding language to reiterate the intent of the document to serve as a conceptual framework for assisting the planning process and to emphasize that planning still needs to occur at the state, local, and institutional level to develop specific operational details and implementation steps. The Ethics Subcommittee also added a section on special considerations relating to children.



The Ethics Subcommittee hopes to finalize this document so that it can be of assistance to the public health officials who act “on the front lines.” These issues have been raised in the Ethics Subcommittee’s series of Webinars, Ms. Bernheim noted.

Discussion Points

- Dr. Sanchez thanked the Ethics Subcommittee for its work in creating the ventilator allocation document, and for gathering input from a wide range of public health practitioners and emergency responders. People in the field are clearly thinking about these issues, and are in need for a framework of ethical considerations as they plan.
- Ms. Bernheim acknowledged the service of Cass Wheeler, who will rotate off the ACD at the end of June 2011. He has been an important member of the Ethics Subcommittee, and they have appreciated his insights. With his departure, there is an opening for a second ACD representative on the Ethics Subcommittee. Any interested ACD members should contact Ms. Villar, Dr. Barrett, or Dr. Sanchez. Ms. Bernheim offered to speak with anyone who had questions about the Subcommittee.

Motion

It was moved and seconded to accept the Ethics Subcommittee report on ventilator allocation. The ACD accepted the document unanimously, with Dr. George Isham and Dr. Anthony Iton abstaining.

National Biosurveillance Advisory Subcommittee Final Report: “Improving the Nation’s Ability to Detect and Respond to 21st Century Health Threats: Second Report of the National Biosurveillance Advisory Subcommittee”

Dr. Sanchez reminded the group that the National Biosurveillance Advisory Subcommittee (NBAS) was established by the ACD in May 2008 as a result of a mandate in Homeland Security Presidential Directive-21. The Biosurveillance Coordination Activity in CDC’s Public Health Surveillance Program Office provides support to the NBAS. The Subcommittee is charged with providing biosurveillance recommendations to the federal government. The first report of NBAS was completed in April 2009 and was approved at the ACD Meeting in October 2009. Dr. Sanchez acknowledged the tremendous amount of work conducted by NBAS members. The second iteration of NBAS began its work last summer.

NBAS Co-Chair, Dr. Jeffrey P. Engel, provided an overview of the NBAS final report. Six workgroups were responsible for preparation of the report, and recommendations contained therein represent the input of the entire subcommittee. The process was highly collaborative, and the six workgroups included the following:

- Governance (Inter-Agency Collaboration and Engagement)
- Healthcare and Public Health Information Exchange
- Innovative Information Sources
- Global and Regional Biosurveillance Collaboration



- Biosurveillance Workforce, New Professions and Cross-Training
- Integrated Multi-Sector Information

Dr. Tom Frieden, CDC Director, attended the NBAS meeting in August 2010. He suggested that NBAS focus on thoughts to action and concrete recommendations. The Subcommittee appreciated Dr. Frieden's attendance and comments, and the workgroups subsequently conducted 46 meetings and 74 briefings. The group maintains a GoogleDocs collaborative website containing over 230 documents. The workgroup reports were completed on January 31, 2011. On February 1, 2011, the NBAS co-chairs and workgroup champions met to review the reports and identify common themes, determining the direction of the NBAS report recommendations.

NBAS Co-Chair, Dr. W. Ian Lipkin, emphasized that the NBAS members worked together closely and the Subcommittee was unanimous in its recommendations. The first NBAS report was the basis of their work, and many of the recommendations in the first report continue into the second. He presented the following four consolidated themes that emerged from NBAS's most recent discussions:

- Governance
- Information Exchange
- Workforce Needs
- Research and Development

Dr. Pamela S. Diaz (Director, Biosurveillance Coordination, Public Health Surveillance Program Office, Office of Surveillance, Epidemiology, and Laboratory Services (OSELs), Designated Federal Officer, NBAS) commented that the report represents a successful next step in providing recommendations to the federal government. Members of the National Security Staff of the White House have engaged the Subcommittee over the course of its deliberations, and there appear to be first steps underway toward organizing the biosurveillance enterprise of the federal government. A sub-inter-agency policy committee has been formed. She pointed out that the second NBAS report includes the individual workgroup reports, which were attached as appendices to the report.

Motion

It was moved and seconded to accept the second report from NBAS. The motion was unanimously accepted, with no abstentions.

**State, Tribal, Local, and Territorial (STLT) Workgroup:
Directional Recommendations for Enhancing CDC Support to STLT Community**

Dr. Sanchez introduced the State, Tribal, Local, and Territorial (STLT) Workgroup, which is chaired by Dr. David Fleming, and which includes several ACD members. He emphasized that a Workgroup is different from a Subcommittee, and noted that the next ACD meeting would include guidance on these differences. The STLT Workgroup was created to provide input to the ACD on STLT public health policies and priorities; provide



input as requested to the ACD regarding other CDC programs; and provide public health practice input to the ACD from the STLT community to assist in translating public health science and innovation into practice.

Public health is facing unprecedented challenges, from economic challenges to NCDs. Public health entities and jurisdictions bear the brunt of the current economic environment and inevitable budget cuts. CDC will need to be an effective partner in helping to address STLT public health issues. To answer this need, in October 2010, the ACD issued a specific charge to the STLT Workgroup to produce recommendations for the ACD to consider how CDC should provide assistance and frame new and existing grants to maximize resources to develop the needed capacity throughout the STLT community. This assignment is large and open-ended.

This presentation is the start of a conversation. The Workgroup generated 18 recommendations across four focus categories: Flexibility, Outcome-Focused and Accountable, Substantial Engagement, and Technical Assistance. The STLT Workgroup is requesting that ACD review the directional recommendations, provide input, and determine next steps.

STLT Workgroup Chair, Dr. David Fleming, pointed out that the charge to the STLT Workgroup recognizes that much, if not most, of CDC's effect in the United States is as a result of the monies that flow from CDC to governmental public health partners at the state, tribal, local, and territorial levels. The STLT Workgroup was asked to make recommendations regarding how to improve that process. These recommendations are a high-level, conceptual first pass. The STLT Workgroup seeks approval to further vet these recommendations within CDC in order to proceed and generate more specificity. This task is especially relevant now, given funding pressures and the likelihood of budget reductions at all levels of government, which will require that they conduct business more efficiently. The STLT Workgroup created a sub-group to consider these issues. Dr. Fleming acknowledged the hard work of this group. A breadth of expertise from all aspects of governmental public health was represented on the workgroup. Rather than focusing on the mechanics of how monies are distributed, the workgroup instead examined larger policy issues.

CDC's operating environment is undergoing important changes. Continued cuts in domestic spending are expected, and changes to, or repeal of, PPACA are possible. Cuts to CDC's budget are probable. Mechanisms for how the cooperative agreement process works are not just determined by CDC, but in conjunction with the Department of Health and Human Services (HHS) and Congress. Important transformations in public health practice are also occurring at the STLT level. Most state and local health departments have endured years of budget cuts. Consequently, some core public health programs and efforts are increasingly at risk not only due to budget shortfalls, but also due to the slowing of hiring and contracting processes. Public health infrastructure has never been well-funded, and it is especially fragile in this environment as increasing requirements are being placed on the infrastructure to do its job more efficiently and effectively. Tremendous loss in capacity has occurred at the state and local level, with about 20% of the state health department workforce and about 15% of the local health department workforce being cut in the last few years.

The workgroup established a vision for how the cooperative agreement process could be improved. The current process does not fail in these areas, but the group felt that



progress could be made in these areas. There is a need to prioritize and target resources to the most pressing health needs of the country. There is inefficiency in the current categorical, or siloed approach to funding. In an era of increased demands for accountability and performance, clearer goals and objectives with measurable outcomes should be developed. With increasing sophistication in the public health workforce, active partnerships should be cultivated between CDC and STLT groups. The evidence and science bases are critical to the work they do, but many of their problems are not fully amenable to attack by proven science. Therefore, there is a need to remain innovative. Although funding is likely not to be stable, the cooperative agreement process should assume that funding will be long-term and reliable. With reductions in infrastructure, funds should be better used for critical infrastructure needs.

Dr. Fleming described the Workgroup's recommendations to CDC in each of the categories:

Flexibility

- CDC should work with HHS to determine strategies for greater flexibility to award funds for jointly developed deliverables that cut across current categorical programs.
- CDC should evaluate feasibility and, where possible, grant awards that are bundled or integrated, rather than limited or categorical in nature.
- CDC should enable funding and coordination of linked or common activities that cross multiple grants within a single jurisdiction.
- CDC should develop and implement a process to better define and fund program-related and agency-wide infrastructure costs that are necessary for effective execution of grants.
- CDC should think about new cross-jurisdictional approaches, incentivizing collaborations across states, tribes, territories, and counties with unified funding.
- CDC should develop a new mechanism for quickly resolving questions about expenditures and grant funds. This recommendation does not suggest a "court process," but a streamlined way to resolve disagreements.
- CDC should support a more interactive process at the start of a cooperative agreement, which would allow for openness and innovative approaches.

Outcome-Focused and Accountable

- CDC should create incentives that enable the use of grant funds to attack not only end-stage disease issues, but also the causal social determinants that underpin specific program goals.
- CDC should develop consistent, cross-CDC guidance to balance and define the use of metrics for both process and outcome accountability in Cooperative Agreements.
- In adopting a categorical approach, it is possible to "lose sight" of what the overall public health enterprise seeks to accomplish. CDC should encourage a strategic focus on balancing those categorical outcomes with public health system enterprise objectives. For example, surveillance systems should be designed into a "horizontal" approach at the state and local level, rather than being only for one disease.

- ❑ CDC should recognize the need for innovation and develop specific approaches that enable a balance of innovation and the evidence base.
- ❑ In this era of increased accountability and attention to performance, CDC should support the Public Health Accreditation Board (PHAB) process as a beneficial measure of infrastructure and capacities.

Substantial Engagement

- ❑ CDC should seek meaningful input in a consistent and predictable way from the STLT community in areas such as making the business case, setting priorities, determining goals and objectives, and selecting intervention and evaluation methods.
- ❑ CDC should establish enterprise-wide, consistent principles related to the Cooperative Agreement approach. CDC has a wide reach, but there is inefficiency in the different rules and processes that govern cooperative agreements across different centers, institutes, and offices (CIOs). At the execution level, these differences are complicated.
- ❑ CDC should consider the nature of the expertise provided by Project Officers. These Officers guide the grants' execution and should have expertise in grant management issues and in technical issues.
- ❑ CDC should hire, train, and recruit Project Officers with a knowledge of current and emerging best practices as well as an extensive understanding of the diversity and reality of practice in the field.

Technical Assistance

- ❑ CDC should consistently offer grantees access to program expertise using not just internal, but external stakeholder organizations and contractors. More peer-to-peer assistance across Cooperative Agreements would be a promising approach.
- ❑ CDC should prioritize working with grantees toward a process of continuous quality improvement (CQI) of program effectiveness.

Regarding the next steps envisioned by the STLT Workgroup, the broad recommendations presented by the workgroup should be translated into more specific recommendations which can be operationalized. There should be work within the Workgroup and with Office for State, Tribal, Local and Territorial Support (OSTLTS) to develop an on-going process to operationalize the recommendations. The Workgroup felt that additional issues remain that are not addressed in this set of recommendations. The group would like to address these issues in the future. Examples include: 1) Formula versus competitive funding for cooperative agreements. Competitive funding may allow dollars to go to those who are best able to deliver programs. Formula funding assures that the areas that are most in need receive resources; and 2) In terms of eligibility for cooperative agreements, particularly at the local level, should metropolitan areas or small health departments be direct recipients of grants, or should funds flow through state health departments? More work is also needed to develop a suite of process and outcome metrics that is more consistent across cooperative agreements and will allow for a demonstration of performance.

The workgroup recommended that OSTLS take the recommendations, with any modifications or changes suggested by ACD, and vet them to obtain CDC's perspective of their merit and to generate specific ways to execute them. The STLT Workgroup will then



incorporate those results into a more specific and final set of recommendations for the full ACD during the October 2011 meeting.

Discussion Points

- Dr. Sanchez noted that the ACD is not “shy to talk.” Their compressed time schedule and telephone meeting may have caused them to self-censor, but he assured the new ACD members that lively discussion would take place at their in-person meeting. He thanked Dr. Fleming for the presentation and appreciated that CDC is working on these issues.
- Regarding the “Outcome-Focused and Accountable” recommendations, Sara Rosenbaum, BA, JD, George Washington University, asked for an example of a specific issue that CDC works on in collaboration with stakeholders and how these recommendations might play out in practice.
- Dr. Fleming replied that the workgroup hopes to take the next step to work with individual CDC programs to vet the recommendations and to increase their specificity. CDC is moving in this direction in its chronic disease granting programs. Historically, this program has included a large number of categorical grants around specific disease issues. While they have been effective, the programs may not have been as efficient as they could be because of a lack of consistency across approaches, especially in terms of how outcomes are defined, how specific rules of the agreements work, the number of different program officers, and other issues. Improved communication will help alleviate transaction costs at the local and state levels as those officers translate multiple, independent funding streams into a coordinated community approach. Synthesizing and combining programs with common processes and practices will increase efficiency. Many factors underpin an effective chronic disease program, including expertise in advocacy, communications, and other areas. No individual grant provides that necessary infrastructure support. Designated funding is needed for this kind of support across grants.
- Regarding the recommendations under “Technical Assistance,” George Isham, MS, MD, Chief Health Officer and Plan Medical Director, HealthPartners, commented that CQI is one type of management technique that focuses on process improvement. In this context, he asked whether the workgroup considered CQI in a narrower, technical sense or in a broad sense that encompasses a broader suite of process management tools.
- Dr. Fleming clarified that the group’s intent was to think broadly about the various available methodologies for improving program effectiveness.
- Dr. Bal acknowledged the excellent work done by the workgroup chair and OSTLTS staff. He noted that Dr. Anthony Iton has a model for addressing social justice issues early in the process of structural change. He felt that it would be useful to add Dr. Iton, or someone with similar expertise, to the workgroup.
- Anthony Iton, MD, JD, MPH, Senior Vice President for Healthy Communities, the California Endowment, expressed that he would enjoy participating in the workgroup and noted his appreciation for their work thus far. He felt that great progress had been made in thinking about the relationship between CDC and the STLT community. This area is critical for advancing chronic disease and health equity practices.
- As there were no additional comments, Dr. Sanchez thanked Dr. Fleming and those who had worked hard to generate the recommendations. The recommendations are



Advisory Committee to the Director: Record of the April 28, 2011 Meeting

in line with the mission of CDC and the public health enterprise. There was support for the STLT Workgroup moving forward as planned.

- Dr. Fleming said that he would return to the Workgroup with the understanding that ACD's support was at a sufficiently high level for the Workgroup to proceed and move through the vetting process.

Global Workgroup (GWG) Update

Global Work Group Chair, Dr. Alan Greenberg, offered updates on the Global Workgroup (GWG). He thanked his fellow ACD members on the workgroup and invited any of the new ACD members to join them. GWG is a new workgroup of the ACD, which was charged to gather information for the ACD and make recommendations to the ACD regarding the newly-formed Center for Global Health (CGH) at CDC. The first GWG meeting was convened prior to the ACD meeting in October 2010. This workgroup includes ACD members, external experts, international representatives, and senior leadership at the CGH. Dr. Greenberg presented a summary of their discussions at the ACD meeting on October 28, 2010. He created a brief summary report, and the full content of the meeting was reported via detailed minutes of the meeting, both of which have been reviewed by the GWG and are provided to the ACD.

The second meeting of the GWG was held in Atlanta on April 27, 2011. The workgroup felt that it would be of benefit to convene another in-person meeting in advance of this ACD meeting. Given the reformatting of the ACD meeting, they did not have complete attendance, but did have good representation. The CGH provided further updates on its important work, and numerous other CDC centers summarized their global health activities. This meeting gave the GWG and the CGH the opportunity to better understand the wide spectrum of global activities at CDC. The GWG will develop a brief summary of the second meeting, and the CGH will provide the full meeting minutes to the ACD in advance of the next ACD meeting.

Discussion Points

- Larry Slutsker, MD, MPH, Associate Director for Science, CGH, spoke on behalf of the center. He thanked Dr. Greenberg for his work, noting that the GWG was a strong partner with the center.
- Dr. Fleming added that the new Center holds tremendous promise.
- Dr. Sanchez said that the GWG would be included on the agenda of the fall 2011 ACD meeting.

Public Comments

No public comments were offered during this ACD meeting.

Closing Remarks

Ms. Villar thanked Dr. Sanchez for chairing the meeting, and she thanked the ACD members for their time and flexibility. During the next meeting, language will be provided regarding workgroup specifics. She thanked Gayle Hickman for her hard work.



Advisory Committee to the Director: Record of the April 28, 2011 Meeting

Dr. Sanchez thanked all of those who support the subcommittees and workgroups. He summarized the results of the meeting, reminding everyone that they addressed important issues concerning ethical considerations for non-communicable disease interventions; they voted to accept the ventilator allocation document from the Ethics Subcommittee; they voted to accept the second NBAS report; the STLT Workgroup presented a set of recommendations; and they will hear more from the GWG during the Fall 2011 meeting.

Dr. Sanchez thanked the ACD members who would rotate off of the committee on June 30, 2011, including Nick Baird, Nisha Botchwey, Ken Mandl, John Seffrin, and Cass Wheeler. He thanked them all for the work they had done in support of CDC and in support of the health of the nation.

Dr. Bal asked about the next steps for the report from the Ethics Subcommittee regarding ethical considerations in non-communicable disease interventions. He suggested that the presentation serve as an opening foray into the issues, but that they discuss it further due to the possibility that it could be used by industry for purposes other than they intended. Dr. Sanchez agreed and asked them to keep that precautionary point in mind.

Motion

It was moved and seconded to adjourn the meeting. The motion was approved unanimously, and Dr. Sanchez adjourned the meeting at 2:47 p.m.



Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 28, 2011 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, CDC



Attachment #1: Attendance

ACD Members Present:

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

Chief Executive Officer, Alliance to Make US Healthiest and
President, Stillwater Solutions, LLC

Dileep G. Bal, MD, MS, MPH

Kauai District Health Officer
Island of Kauai, Hawaii

Nisha D. Botchwey, MCRP, PhD, MPH

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

Benjamin K. Chu, MD, MPH, MACP

President, Southern California Region
Kaiser Foundation Health Plan, Inc. and Hospitals

Sanford R. Climan, MBA, MS

President, Entertainment Media Ventures

Suzanne Frances Delbanco, PhD

Executive Director
Catalyst for Payment Reform

Sylvia Drew Ivie, JD

Senior Deputy for Human Services and Development
Office of Supervisor Mark Ridley Thomas
Second District, Los Angeles County Board of Supervisors

Thomas A. Farley, MD, MPH

Commissioner
New York City Department of Health and Mental Hygiene

David W. Fleming, MD

Director and Health Officer for Public Health
Seattle and King County
Chair, STLT Workgroup

Alan E. Greenberg, MD, MPH

Professor and Chair
Department of Epidemiology and Biostatistics
George Washington University School of Public Health and Health Sciences
Chair, Global Workgroup

George Isham, MD, MS

Medical Director and Chief Health Officer
HealthPartners, Incorporated



Anthony B. Iton, MD, JD, MPH

Senior Vice President, Healthy Communities
The California Endowment

Mary Kelly

Executive Vice President
Merchandising and Category Management
Shoppers Drug Mart

Jonathan T. Lord, MD

Chairman of the Board
DexCom, Inc.

Kenneth D. Mandl, MD, MPH

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

Sara Rosenbaum, JD

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

Eduardo J. Sanchez, MD, MPH, FAAFP

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

M. Cass Wheeler

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

ACD Members Absent:

Kelly J. Henning, MD

Director, International Health Programs
Bloomberg Foundation

John R. Seffrin, PhD

Chief Executive Officer
American Cancer Society



Subcommittee Chairs Attending:

Ruth Gaare Bernheim, JD, MPH

Chair, Department of Public Health Sciences, School of Medicine
Associate Director, Institute for Practical Ethics and Public Life
University of Virginia
Chair, Ethics Subcommittee

Jeffrey P. Engel, MD

State Health Director for North Carolina
Division of Public Health
Co-Chair, National Biosurveillance Advisory Subcommittee (NBAS)

W. Ian Lipkin, MD

John Snow Professor of Epidemiology
Director, Center for Infection and Immunity
Mailman School of Public Health
Columbia University
Co-Chair, National Biosurveillance Advisory Committee (NBAS)

CDC Staff Attending:

Ileana Arias, PhD

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

Drue Barrett, PhD

Lead, Public Health Ethics Unit
Office of the Science Integrity
Office of the Associate Director for Science
Office of the Director
Designated Federal Officer, Ethics Subcommittee

Mark Biagioni, MPA

Public Health Analyst
Office of the Principal Deputy Director

Mark Byers

Management and Program Analyst
Biosurveillance Coordination Activity
Public Health Surveillance Program Office
Office of Surveillance, Epidemiology, and Laboratory Services

Janet Collins, PhD

Associate Director for Program
Office of the Director



Advisory Committee to the Director: Record of the April 28, 2011 Meeting

Linda Degutis, DrPh, MSN

Director
National Center for Injury Prevention and Control
Office of Noncommunicable Diseases, Injury and Environmental Health

Pamela Diaz, MD

Director, Biosurveillance Coordination
Public Health Surveillance Program Office
Office of Surveillance, Epidemiology, and Laboratory Services
Designated Federal Officer, National Biosurveillance Advisory Committee

Kevin Fenton, MD, PhD, FFPH

Director
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
Office of Infectious Diseases

Kathryn Foti, MPH

Special Assistant to the CDC Director

Donna Garland, BA

Associate Director for Communication
Office of the Director
Designated Federal Officer, Communications Workgroup

Rana Hajjeh, MD

Division Director
Division of Bacterial Diseases
National Center for Immunization and Respiratory Diseases
Office of Infectious Diseases

Sonja S. Hutchins, MD, MPH, DrPH (SSH1)

Senior Medical Epidemiologist
Office of Minority Health and Health Equity (Proposed)

Gayle J. Hickman

Logistics Specialist
Advance Team
Office of the Chief of Staff
Office of the Director

Robin Ikeda, MD, MPH, CAPT, USPHS

Director for Noncommunicable Diseases, Injury and Environmental Health

Rear Admiral Ali S. Khan, MD, MPH

Assistant Surgeon General
Director, Office of Public Health Preparedness and Response

Rima Khabbaz, MD

Director for Infectious Diseases



Gladys. G. Lewellen, MBA, MPA

Federal Advisory Committee Management Policy and Oversight Team Lead
CDC Committee Management Officer
Management Analysis and Services Office

Leandris Liburd, PhD, MPH

Director, Office of Minority Health and Health Equity (Proposed)
Designated Federal Officer, Health Disparities Subcommittee

Judy Lipshutz, MPH

Public Health Analyst
Office for State, Tribal, Local and Territorial Support
Office of the Director

Amy Loy

Public Health Advisor
Knowledge Management Branch
Division of Public Health Capacity Development
Office for State, Tribal, Local and Territorial Support

Kathy Meyer, MBA

Federal Advisory Committee Management Branch
Management Analysis and Services Office

Judy Monroe, MD

Director, Office for State, Tribal, Local and Territorial Support
Designated Federal Officer, State, Tribal, Local and Territorial Workgroup

Ron Otten, PhD

Director
Office of Scientific Integrity
Office of the Associate Director for Science

Nancy Peterson

HR Specialist
Office of the Chief of Staff

Harald Pietz

Senior Advisor
Technical Assistance Branch
Division of Public Health Capacity Development
Office for State, Tribal, Local and Territorial Support

Robert Pinner, MD

Associate Director, Informatics
National Center for Emerging and Zoonotic Infectious Diseases
Office of Infectious Diseases



Tanja Popovic, MD, PhD, F(AAM), AM(AAFS)

Deputy Associate Director for Science
Office of the Associate Director for Science

Christopher J. Portier, PhD

Director
National Center for Environmental Health/Agency for Toxic Substances and Disease
Registry
Office of Noncommunicable Diseases, Injury and Environmental Health

Andrew S. Rein, MS

Associate Director for Policy
Office of the Associate Director for Policy
Office of the Director

Laurence Slutsker, MD, MPH

Associate Director for Science
Center for Global Health

Dixie Snider, MD, MPH

Special Consultant
Innovation and Special Project Activity
Office of the Associate Director for Science

Esther Sumartojo, PhD, MSc

Associate Director for Science and Public Health
National Center on Birth Defects and Developmental Disabilities
Office of Noncommunicable Diseases, Injury and Environmental Health

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

Director, Office of Surveillance, Epidemiology, and Laboratory Services

Timothy W. Van Wave, DrPH

Branch Chief (Acting) and Health Scientist
Research and Outcomes Branch
Office for State, Tribal, Local and Territorial Support

Carmen Villar, MSW

Chief of Staff
Designated Federal Officer, ACD

Curtis Weaver, BS, MFA

Public Health Advisor
Biosurveillance Coordination Unit
Public Health Surveillance Program Office
Office of Surveillance, Epidemiology, and Laboratory Services



General Public

Kendra Cox

Cambridge Communications, Atlanta, GA
CDC Contractor Writer/Editor

Lynn R. Goldman, MD, MS, MPH

George Washington University School of Public Health

David Kittross

Senior Editor, CD Publications

Lynne D. Richardson, MD, FACEP

Mount Sinai School of Medicine

Charles Stokes

President and CEO
CDC Foundation

Chloe Knight Tonney

Vice President for Advancement
CDC Foundation

Carrie S. Zoubul, JD, MA

New York State Department of Health



Attachment #2: Acronyms Used in This Document

Acronym	Expansion
ACD	Advisory Committee to the Director
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health (CDC)
CIOs	Centers, Institutes, and Offices
CQI	Continuous Quality Improvement
DARPA	Defense Advanced Research Projects Agency
DFO	Designated Federal Official
DHS	Department of Homeland Security
DoD	Department of Defense
GWG	Global Work Group
HHS	(Department of) Health and Human Services
NBAS	National Biosurveillance Advisory Subcommittee
NCD	Non-Communicable Disease
NIH	National Institutes of Health
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSTLTS	Office for State, Tribal, Local and Territorial Support
PHAB	Public Health Accreditation Board
PPACA	Patient Protection and Affordable Care Act
STLT	State, Tribal, Local, and Territorial (Workgroup)
TB	Tuberculosis
USDA	United States Department of Agriculture

