

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Office of Public Health Preparedness and Response (OPHPR)
Board of Scientific Counselors (BSC) Web Conference

SUMMARY REPORT/RECORD OF THE PRECEEDINGS

Tuesday, February 13, 2018; 2-5 PM EST

Roybal Campus, Building 21, Room 6116

Atlanta, Georgia

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Roll Call, Review of Federal Advisory Committee Rules, Duties, and Conflict of Interest

Samuel Groseclose, DVM, MPH; Associate Director for Science, OPHPR and Designated Federal Official, OPHPR BSC

Dr. Groseclose began the meeting by conducting roll call. Quorum was present. He then reviewed the Federal Advisory Committee activities.

Members were asked to notify Dr. Groseclose before leaving portions of the meeting to ensure that quorum is maintained. The meeting was led by Dr. Inglesby, the Chair. Discussions and deliberations are among BSC members, Ex Officio members, Liaison representatives, and CDC leadership. Voting is conducted only among the BSC and Ex Officio Members. The public is allowed to comment during the Public Comment portion of the agenda only. All speakers consent to identifying themselves and to having their comments monitored and recorded for the purpose of creating a meeting summary.

Dr. Groseclose reviewed the BSC responsibilities as per its charter. All Confidential Financial Disclosure Status Report Form should have been reviewed prior to the start of the meeting. If any changes have occurred since the last submittal, they were to be forwarded to Dr. Groseclose. Members were asked to identify any conflicts of interest. Dr. Inglesby reported no changes since the last meeting and he is a subcontractor on the OPHPR-funded COPEWELL project to research community resilience. His colleague, Tara Kirk Sell is the principal investigator for a CDC-funded communication-focused project. Dr. Catherine Slemp is also collaborating on the community resilience project.

Dr. Groseclose also introduced the CDC leadership present for the web conference.

Welcome & Call to Order / Introductions & Opening Remarks

Thomas Inglesby, MD; Chair, OPHPR BSC

Dr. Inglesby thanked all participants of the meeting for their commitment and efforts. He also thanked OPHPR leadership and its staff for facilitating the web conference. These engagements, he said, allow OPHPR to hear valuable input and recommendations from the board, as well as approval of the direction the Division is taking. Giving consideration to the current events, like the new budget and government, domestic preparedness activities, and international occurrences that affect U.S. preparedness efforts, he felt it was important to have the web conference to hear of OPHPR's response updates.

OPHPR Update

RADM Stephen C. Redd, MD; Acting Principal Deputy Director, CDC

Dr. Redd provided a chronology of some of the changes that have occurred in the last few months. On November 17, 2017, Dr. Fitzgerald appointed Dr. Redd as the Deputy Director for Public Health Services. In his new role, he is responsible for establishing and managing a community of practice that includes OPHPR, the Center for Global Health, the Office of State Tribal, Local and Territorial Services (OSTLTS), and the Office of Minority Health and Health Equity. This position fits well with several horizontal offices like the Office of Infectious Diseases, Office of Noninfectious Disease and Environmental Health, and the Office of Public Health and Scientific Services. Most of the organizational change required to support this new structure has occurred in the last few weeks.

In the same timeframe, January 31, 2018, Dr. Fitzgerald resigned as Director of CDC. This resulted in Dr. Redd being asked to serve as acting Principal Deputy Director of CDC and Dr. Sosin taking on the role of acting OPHPR Director.

In addition to the organizational changes, OPHPR is still engaged in the hurricane response, specifically in Puerto Rico and the U.S. Virgin Islands. The main activities occurring in Puerto Rico include ensuring the immunization program resumes full functionality, reestablishing the public health laboratory, and addressing ongoing environmental health issues. The response work will probably continue to occur for several more months.

Over the past 18 months, OPHPR has worked on planning efforts for several high risk scenarios that will strengthen preparedness capabilities. The Nuclear Detonation Incident Command System performed an exercise as part of the larger governmental response in 2017. In September 2018, OPHPR will be convening a pandemic influenza exercise. An anthrax event response exercise will follow soon after as the next training.

The Division of Emergency Operations (DEO) has begun training the second cohort for the Incident Manager Training and Development Program. The first cohort completed their training at the end of 2017. This program prepares future incident managers for leadership.

The Division of State and Local Readiness (DSLRL) is in the second round of its Operational Readiness Review. The evaluation instrument used for assessing a jurisdiction's capabilities to dispense medical countermeasures (MCM) has undergone extensive revisions.

The Division of Select Agents and Toxins' (DSAT) IT system continues to be refined. The system will allow the program data to be managed electronically rather than based on review and analysis of paper-based records.

Lastly, when the President recently released the budget, it was learned that the Strategic National Stockpile will move from the control of CDC to the control of the Assistant Secretary for Preparedness and Response (ASPR) effective October 1, 2018. OPHPR is working to ensure a seamless transition. Several elements contributed to this decision. The biggest of those was the need to unify the MCM enterprise so that development work by the Biomedical Advanced Research and Development Authority (BARDA) and procurement by the Division of Strategic National Stockpile (DSNS) would be under the same organizational umbrella. Efforts are being made to ensure that connections between the state and local health departments through the DSLR and the medical expertise at CDC providing guidance on MCM utilization are retained. Five workgroups have been formed to assist with the transition.

Dan Sosin, MD, MPH; Acting Director, OPHPR

After the concise remarks of Dr. Redd, Dr. Sosin expressed a feeling of honor to serve in his role as acting OPHPR Director and looks forward to working closer with the BSC, while Dr. Redd is assuming his new position. Given his past work with the BSC, the shift in roles should cause no disruption to OPHPR.

Biological Agent Containment Working Group (BACWG) Update

Dawn Wooley, PhD; BACWG Co-Chair, BSC Member

Dr. Wooley provided an update of the BACWG's work since their November 1, 2017 in-person meeting. At the meeting, the Polio Containment Activity and DSAT presented an overview of their programs. The Polio Containment Activity reported on their policy development process and review. They presented two policies to the workgroup for review, discussion, and approval.

With regard to policy development, the BACWG seeks to implement the World Health Organization's Global Action Plan III (GAPIII). This is a polio eradication initiative. Each country is to adopt the plans and if needed develop policies for containing polio. The policies reviewed at the November 1st meeting were physical security and record of access.

Discussions at the meeting also included deliberations on future engagements. Monthly BACWG meetings will occur by teleconference and started in December. The main task of those meetings will be to review policy. The Polio Containment Activity staff will draft policies that will be distributed, discussed, edited as necessary, and adopted by the workgroup. These activities will occur for approximately six months.

Some action items for the Polio Containment Activity were created at the November 2017 meeting. They were as follows:

- Draft policies for all of the elements in the GAPIII to be presented to the workgroup.
- Create a collaborative community with the polio essential facilities using the Office of Laboratory Animal Welfare Interagency Collaborative Animal Research Education (OLA ICARE) as a potential model.
- Work with DSAT to assess the security risk of polio viruses using the select agent criteria and gain a full understanding of work occurring in potential polio essential facilities.
- Generate a strategy and vision statement to provide context to the polio essential facilities and partners that will assist in developing oversight policies.

The workgroup conducted three one-hour teleconferences in December, January, and February. During the teleconferences, the working group outlined specific polio virus containment activity priorities requiring review, as well as, discussed the GAP and associated risks. The workgroup also finalized and approved the two policies reviewed during the February 2017 in-person meeting. The first policy reviewed was in regard to virus storage outside of containment. Finalization of the review is soon to be completed during the teleconferences. The next policy will pertain to inventory.

A report of the first six months of activities will be given at the May 2018 BSC in-person meeting. The report will include a list of polio containment activity policies approved by BACWG. After presenting the policies, BACWG chairs, Dr. Wooley and Dr. Slemple, will ask for endorsement of the report by the BSC.

There have been some membership changes in the BACWG. Dr. Slemple has joined and is replacing Dr. Alonzo Plough as the Co-Chair. Dr. Tom Inglesby and Dr. Suzet McKinney have joined the workgroup, as well as Dr. Kevin Esvelt, who has expertise in synthetic biology.

Cathy Slemple, MD, MPH; BACWG Co-Chair, BSC Member

Dr. Slemple added the BACWG is assessing the environment, programs, and facilities in which these policies will be developed. The policies and guidelines currently are voluntary for polio facilities; therefore, communication, collaborative relationships and engagement of facilities while developing the policies is paramount. It is important to assess and understand the risk of release, ways that release

might happen, and the importance of containment. This underscored the need to generate a risk statement that communicates the importance and rationale behind making changes to processes. Labs understand the importance in part but as the focus moves to work with potentially infectious materials the understanding of risk and the need to implement the policies that the BACWG is proposing may not be fully comprehended.

As Dr. Wooley reported, most of the workgroup's efforts have been around policy development but as the group gains more traction in its work, it will look to the BSC to recommend broader issues around biological containment/biological security that should be considering in its work.

Recommendations/Comments from the BSC to the BACWG:

- Compile or recap the histories and lessons learned. Risk management has to be upgraded and cannot be completed with only one group or perspective. Also, generate a summary of how risk management has evolved and how it compares with other exercises and initiatives. These should provide a clearer outlook.

DEO's Excellence in Response Operations – Outcomes and Next Steps

Jeff Bryant, MS, MSS; Director, Division of Emergency Operations

Mr. Bryant provided the BSC with some of the outcomes of the Excellence in Response Operations (ERO) work undertaken by DEO and the future steps for 2018. He began his presentation with a quick summary of what was presented at the in-person BSC meeting in October 2017.

The Excellence in Response Operations Initiative is a preparedness activity that was conceptualized during the Ebola and Zika responses. The purpose of the initiative is to allow CDC to respond more efficiently in its future emergency response efforts. Response to public health emergencies is not exclusive to OPHPR but is an agency-wide effort. Therefore, partnerships have been made with other Offices and Divisions at CDC in an effort to develop solutions that represent a broader perspective on needed activities for a response. Thus far, 124 Centers, Institutes, and Offices (CIO) staff members across the agency have worked with the Division of Emergency Operations (DEO) on its initiative.

An analysis has been conducted on CDC After Action Reports from 2012 to present. The observations from the reports were grouped into buckets of work. Some of those areas requiring additional work include information management/data management in a response; scientific readiness in a response; global operations; domestic operations; responder wellbeing; and staffing capabilities. The DEO partnered with the agency's CIOs to co-lead the initiative resulting in engagement amount nine workgroups.

The first year of work was somewhat unwieldy, initially; most efforts in 2017 were around operationalizing and streamlining ERO protocols and processes. In the end, 110 risks to the CDC's ability to effectively and efficiently conduct emergency response operations were identified. Those threats were further narrowed to 31 high priority risks or opportunities, where mitigation efforts could be conducted to improve response operations.

After the first 8 months of the ERO work, the hurricane responses began (September 2017). Response efforts to the hurricane were occurring after an already taxing time. CDC was still addressing the remaining tasks from response to the Ebola and Zika events. Furthermore, CDC had not responded to a

major hurricane event in over a decade. This hurricane events afforded the agency the opportunity to evaluate some of the early interventions developed through the ERO initiative. Mr. Bryant highlighted a few examples, which are listed below:

- *Development of a responder website, deploy.cdc.gov.* This website on CDC's Intranet, which during the hurricane response was only available to participants and responders, has now gone live. The full-service website covers the full spectrum of response activities.
- *Creation of a responder survey.* This survey assesses the responders' experiences. Four to five surveys were consolidated into a 7-minute survey. As a result, the response rate of the revised survey increased 35%. The survey auto-populates demographic information including deployment location and duration thereby decreasing the administrative workload, by 85% over the prior survey models. This has proven to be an attractive feature for those taking the survey.
- *Reconfiguration of the basic starting point for the Incident Management Structure (IMS) for response operations.* This structure was used during the initial few hours and the beginning days of the hurricane response.
- *Use of default standard operating procedures for response finance.* Funding a response without a Congressional supplemental can create a "pick-up" game scenario. These procedures were tested and piloted during the hurricane response, as well, and will help combat funding challenges going forward.

DEO will move forward with what is now titled ERO 2.0, which included refined workgroup structures, better leaders and co-leaders for the 8 workgroups, and inclusion of senior agency officials from across the organization. The effort will also include new partners, like OSTLTS, the Public Health Law Program, the Career Epidemiology Field Officer (CEFO) Program, Public Health Apprenticeship Program, and Epidemic Intelligence Service (EIS) officers.

The Division is looking for thoughts and recommendations from the BSC around a few topics; such as,

- Performance metrics that will track implementation and determine effectiveness of the interventions.
- Mechanisms that can help capture, track, and report evolving risks.
- Ways to integrate new partners and interests.

The DEO is also examining the After Action Review (AAR) Program process. The Ebola response, which lasted three calendar years, resulted in roughly 170 individual observations after removing duplicative information. The Zika response, which extended over two calendar years, yielded 65 AAR observations, after the elimination of duplications. Ways to economize and streamline AAR information is still ongoing.

Going forward, as after-action observations are vetted, they will go into an ERO workgroup for response. A group with cross-CIO representation will address the ARR observation at a system- and agency-level rather than at an individual program level. This approach should lead to better mitigation strategies.

Recommendations/Comments from the BSC to the DEO:

- Allow the BSC to examine the AAR observations, in a way that does not disclose confidential material, at the upcoming May 2018 in-person meeting.
- Share with the BSC before the next meeting the "lanes of work" of the ERO work groups and describe how the DEO currently tracks progress in the different workgroups. This will help the

BSC gain a deeper understanding of the particulars of responses and provide richer dialogue with the BSC and should yield better recommendations/comments.

- CDC seems to be evolving into a learning organization. The board applauds it for taking the new direction.

Opioid Overdose Epidemic Update

Grant Baldwin, PhD, MPH; Director, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control (NCIPC)

In May 2017, Dr. Baldwin presented to the Board and described the burden of the opioid overdose epidemic. The purpose of his presentation today was to update the Board on efforts to leverage state capacity in order to increase preparedness, readiness, and response activities in localities. He provided an update on the status of the burden, priorities, recent investments, new sentinel scientific publications to be released, and recent increased collaborations with OPHPR. In addition, he expressed a desire to hear comments and recommendations on ways to enhance the Division's work.

Drug overdose deaths in the US have never been higher. The 2016 numbers recently released showed 42,000 opioid-related deaths. This is a 30% increase compared to 2015. There have been 350,000 deaths due to opioids since 1999. The epidemic has been framed in three waves: prescription drug use from 1999 to 2010, increased heroin use, and, more recently, use of fentanyl analogs beginning in 2013. The epidemic has caused the U.S. life expectancy to continue to decrease.

Prescription opioid deaths plateaued from 2011 to 2013 but surged again in 2017. There were a little more than 17,000 deaths, which are five times more than those of 1999. Heroin deaths continue to increase, 15,500 in 2016, compared to 3,000 deaths in 2010. Heroin use is growing at a faster rate than any other drug and has increased six-fold in just a few years. Lastly, deaths due to fentanyl and fentanyl analogs have increased from 3,100 deaths in 2013 to almost 20,000 in 2016. Fentanyl-associated deaths are expected to increase even more in 2017. Fentanyl's popularity has increased due to its potency, profitability, and ease of distribution.

A Morbidity and Mortality Weekly Report (MMWR) was released in October 2017 that examined fentanyl use and related deaths in ten states. Over 50% of deaths in those states were positive for fentanyl. In, four out of ten of the states, greater than 10% were positive for carfentanyl, which is 10,000 times more potent than morphine. The northeastern states have received the most impact from the epidemic mostly due to fentanyl use. Roughly 90% of deaths in New Hampshire involved a fentanyl or fentanyl analog. In addition, over half of deaths involving fentanyl also involve heroin, cocaine, and methamphetamines, which underscores that fentanyl is a unique and independent drug threat. These statistics cause the Division to establish more effective response activities.

Dr. Baldwin then reported on some of the current activities the Division is undertaking to address the epidemic. The first initiative was to increase data quality and to track trends. Data need to be more real-time, localized, and actionable. Funding for enhanced surveillance has increased to 33 states versus the previous 12 reported at the last meeting. The data will highlight the state-to-state variations. An MMWR Vital Signs report will be released on March 6, 2018 that examines regional and state variation for syndromic non-fatal emergency department visits in 16 states. A large part of the report will inform emergency departments on response protocols when there are spikes in overdose deaths. State-based programs that support evidence-based prevention activities are also expanding. There are now 45

states, as well as the District of Columbia, funded for this effort. There is also some policy evaluation work as a part of this endeavor.

There's a growing desire to strengthen the relationship between public health and public safety. The collaborations between the high-intensity drug trafficking areas and DEA continues to evolve. The focus of the collaboration is around data sharing, developing localized implementation strategies that are evidence-based, and increasing engagement in local communities. The Division is now funding 13 localized projects known as Combating Opioid Overdose through Community Level Interventions (COOCLI).

The Board was informed in the May 2017 meeting of a large-scale communication campaign using recovering addicts and family members of those lost to the opioid epidemic. The campaign was launched in late September 2017 in four states: Kentucky, Ohio, Massachusetts, and New Mexico. This campaign resulted in 70 million digital impressions and 3.8 million click-throughs to the campaign at [CDC: Rx Awareness](#). Twenty-five states will be funded to tailor and implement the campaign within their localities.

In April or May of 2017, the Opioid Response Coordination Unit was stood up. This unit is a part of the Injury Center's Office of the Director. Its principal purpose is to bridge the work between the Injury Center, the National Center for HIV AIDS STD and TB Prevention, OPHPR, National Center for Birth Defects and Developmental Disabilities, and the Chronic Disease Center and their Division of Reproductive Health. An environmental scan and gap analysis was completed. From that data, a strategic framework was created to direct the Agency's future direction in addressing the opioid crisis.

Dr. Baldwin has increased engagements with Mr. Bryant (DEO) and Ms. Chris Kosmos (DSLRL). The Division was afforded an opportunity to present at the International Association of Emergency Managers in November 2017 and Mr. Bryant joined the Division at the National Governors Association (NGA). This meeting brought together a small group of states who have declared public health emergencies due to the opioid crisis to talk about strengths, weaknesses, challenges, and opportunities. Present at the NGA meeting was gubernatorial representation from Alaska, Arizona, Massachusetts, Maryland, and others.

In addition, Dr. Baldwin's staff met with Mr. Bryant and his deputy last week to think of ways to conduct a staffing assessment. The idea is to create a mission brief that will help community-level readiness. This will aid in putting protocols in place that will enhance monitoring and follow-up and improve recovery trajectories. He also expressed appreciation to OPHPR for the release of a Crisis Notice of Funding Opportunity (NOFO) which should support timely funding of state-based emergency response activities and can be used by multiple CIOs. When the FY18 budget is passed (March?), it will help to further bridge work completed on a state-based level to those in local communities.

Recommendations/Comments from the BSC to NCIPC:

- Since the epidemic is due to a cluster of underlying issues, consider using medical sociologists. The epidemic is the epitome of a sociological and political problem. Different professions address problems from different perspectives and collect different information, which should result in a more robust understanding of the complexity of the epidemic. NCIPC response: The Center is reviewing drug use behaviors and contextual factors to determine if there may be suitable, novel interventions to address behavior change.

- The real opportunity for public health is in the primary prevention area. Please provide an update on the West Virginia intervention project to the Board at a later date.
- If this issue is viewed from the perspective of the employer, the challenge is having individuals who are utilizing medication properly but then also trying to determine impairment levels to decrease chance for further harm to themselves or others. Tangentially related is the legalization of marijuana; there are no marijuana policies that accompany the state laws in that regard. There needs to be a mechanism to quantitatively measure impairment based on the level of the drug in the system. This would be similarly used as it is in the case of alcohol.

Board Discussion of CDC & OPHPR Responses to BSC Member Recommendations from October 2017

Samuel Groseclose, DVM, MPH; Designated Federal Official, OPHPR BSC

Prior to the teleconference, the Board members were furnished with CDC program responses to their recommendations from the October 2017 BSC meeting. This part of the web conference was designed to allow the OPHPR programs to address the Board’s reactions to CDC comments and afford more time for the Board to have dialogue around the CDC programs’ responses. Below is a table that summarizes some of the recommendations that required more discussion.

Recommendation from Document	Response from Board Members
<ul style="list-style-type: none"> • Using standard pipelines to send [laboratory] data for multiple programs to CDC 	<ul style="list-style-type: none"> • Standard interchange mechanisms already exist. The multiple programs within CDC and the CDC laboratory systems are not harmonized and do not utilize them. CDC programs and labs need to use the same types of systems that have been already established. The various systems currently being utilized and the variations in those makes it extremely difficult for the public health laboratories’ IT staff. They are continually having to create new pipelines for sending data to the various segments at CDC. Several years ago, Jan Nicholson and her partners started a harmonization process and it was very beneficial. Something similar should be established for IT communication with the different CDC laboratories. <p>[Dr. Sosin acknowledged that CDC programs/labs are not routinely using standard data interchange methods. He stated that he and Dr. Redd were aware of the burden this created for states and other partners and would continue to promote and encourage use of standard data interchange methods.]</p>
<ul style="list-style-type: none"> • Schools of public health absolutely have to be involved in PHPRR research because they help align the effort with the practice 	<ul style="list-style-type: none"> • Due to the response of concur in principle, there’s concern that the board may not fully understand the recommendation. The

Recommendation from Document	Response from Board Members
<p>community and can ensure education and training of our public health workforce are relevant to the practice community's needs. Schools of public health can provide an opportunity to better integrate PHPRR in the education and training.</p>	<p>challenge with this issue was the disconnect between the practice community and the research community. The intent of schools of public health being involved in the research effort was to close the gap that currently exists between the research community and the practice community recognizing that oftentimes the research and academicians are not in frequent communication with the practitioners. So, the idea was to have schools of public to be a vehicle that helps bridge the gap. The work of the practitioner can be informed by the research effort and vice versa. The ask would be to go back to OAR and make the clarification and find out if their response would change based on the clarification.</p> <p>[Dr. Groseclose stated that OAR acknowledged in other responses within the same document that our research funding approaches encourage active collaborations between practitioners, academics and other researchers. This BSC member comment was a bit more focused on the role of schools of public health as the main partner for PHPR research or as one of several research partners.]</p>

Members were invited to follow up on any of the issues with Dr. Groseclose. He would then report back on any additional BSC feedback received after the meeting at a later time.

DSLRL’s PHPR Capabilities Update Initiative – Orientation and Request for Review

Todd Talbert, MA; Senior Advisor for Program Development, Division of State and Local Readiness (DSLRL)

Mr. Talbert provided a follow-up to Ms. Kosmos’ presentation in the last BSC meeting regarding the Public Health Emergency Preparedness (PHEP) capabilities updates. Mr. Talbert stated that he was tasked with the responsibility of leading the effort to update the fifteen public health emergency preparedness capabilities standards. This project was initiated in the summer of 2017 and the effort should conclude in the spring of 2018.

As covered in previous meetings, the capabilities were established in 2001 and have become national standards for public health preparedness and response. They’re not only a framework for the PHEP Cooperative Agreement but are capability standards that support state and local emergency preparedness program development. They’re also used to develop exercise objectives, inform state and local guidelines, track responses, and define the public health Emergency Support Function 8 (Public Health and Medical Services) concept of operations within the jurisdiction in the case of an incident or in the planning phase.

The update initiative maintained the fifteen capabilities but updated the descriptive content. Review and evaluation by state and local practice communities recommended inclusion of capabilities informing environmental health, public health informatics, and vulnerable populations' interventions. In addition, a program review was conducted in 2015, which included input from CDC CIOs. They suggested additional areas to address in the capabilities.

As the framework was created, revised and existing standards, guidance, and practices from CDC, as well as other sources like FEMA and ASPR, since 2011 were utilized for revising the capabilities and aligning them with program activities. As a result, there's more language for areas such as electronic death registration, electronic laboratory reporting to increase use of HL7 messaging standards, National Syndromic Surveillance Program, electronic laboratory testing and ordering, Tribal inclusion, vulnerable populations, environmental health, radiological hazard response, and pandemic influenza response. Other endeavors going forward will include streamlining language and changing optics and text to a more active voice so it that it relates to response. In addition, resource elements, tasks, and definitions are being sequenced in a more logical manner in the capability descriptions.

Over 150 subject matter experts from the CDC contributed and provided input. Fifteen workgroups were aligned by capability and four additional cross-cutting workgroups were created that addressed environmental health, pandemic influenza, tribal populations, and vulnerable populations. DSLR is also working with OSTLTS to ensure alignment with the Public Health Accreditation Board (PHAB) standards, and NACCHO's Project Public Health Ready. Comments were then adjudicated and shared for commentaries with partner organizations, like ASTHO, NACCHO, CSTE, APHL, and NEMA. Over 200 individuals from partner organizations have provided input and that information has now been incorporated in the revised capability document.

DSLR will now share the updated capabilities with the BSC for their review and recommendations. This should occur around the beginning of March 2018. Mr. Talbert proposed the Board could scope their review to areas such as deal-breakers, game-changers, etc. and not merely focus on line item edits. The document should be reviewed at a strategic level; but DSLR welcomes any other feedback that would strengthen the work.

An adjudication table to use for review comments has been created and will be shared. DSLR plans to coordinate with Dr. Groseclose and provide a draft of the capabilities that can be shared with the BSC for their review and recommendations around the beginning of March. Feedback from the BSC will be shared back to Dr. Groseclose, and DSLR will incorporate the feedback and edits. Opportunities will be afforded to reach out to DSLR for clarifications as needed. BSC comments will not include attributions. The comments once incorporated will be made available to the BSC at their meeting in May 2018.

Recommendations/Comments from the BSC to DSLR:

- It would be useful at the start of the document to layout the rationale for the update; what problems are being solved by the update.

BSC Member Recommendations: May 2018 BSC Meeting Agenda Topics

Samuel Groseclose, DVM, MPH; Designated Federal Official, OPHPR BSC

Board members were asked to make comments regarding the proposed agenda topics. Below are their comments.

Topic from Document	Response from Board Members
<ul style="list-style-type: none"> [Topic not drawn from document] 	<ul style="list-style-type: none"> Include a presentation on major lessons learned and not learned in key areas of preparedness and response. The BSC needs to examine the patterns; what strategies have worked in combating different hazards and disasters; what hasn't worked; and what changes have been implemented as a result of identifying some of the strategies
<ul style="list-style-type: none"> Update on NASEM Standing Committee for the CDC Division of Strategic National Stockpile 	<ul style="list-style-type: none"> Given the new changes in the SNS, it's more essential to receive an update on the transition of the SNS, the transition workgroups, and the state and local input received. The BSC can discuss the great opportunities that may emerge from the transition and ways to leverage this opportunity. Would like to hear how states and locals are doing in terms of ability to dispense. Would also like to receive a summary of the data CDC has been collecting through the OR program.
<ul style="list-style-type: none"> National Biodefense Strategy -- Federal Agency Perspectives Global Health Security Agenda Update 	<ul style="list-style-type: none"> Would be very interested in hearing about these two topics.
<ul style="list-style-type: none"> Nuclear Detonation and Chemical Threat Preparedness and Response 	<ul style="list-style-type: none"> The BSC has not heard recently about environmental health in terms of nuclear and chemical. Those are areas that demand effective responses. What is currently being thought about in that area? It's important to ensure resilience ability is incorporated as part of the response. CDC engages in organizations particularly when they're doing close point of distribution. They need to be incorporated into drills and other operations.
<ul style="list-style-type: none"> Hurricane Response Update 	<ul style="list-style-type: none"> Useful for the Board to hear given how serious the efforts were across the government. Would like a report on the other roles than ran alongside those of CDC from agencies such ASPR and FEMA. It will

Topic from Document	Response from Board Members
	<p>help the board better understand how responsibilities are broken up among the agencies in a response.</p> <ul style="list-style-type: none"> • May be useful for the BSC to hear how the other agencies view CDC and what they're needing from CDC during such a response.
<ul style="list-style-type: none"> • [Topic not drawn from document] 	<ul style="list-style-type: none"> • What is the role of Adverse Childhood Experiences (ACE) and trauma informed care? What is CDC examining or considering in that regard? Would it have implications around preparedness and response in terms of community resilience and vulnerable populations? Should be thinking strategically in terms of what does that mean for preparedness work, and what are the opportunities in utilizing those approaches to build resilience in communities.

Dr. Groseclose also extended an invitation for members to submit further recommendations for May 2018 BSC meeting session topics should others come to mind.

Public Comment Period

Thomas Inglesby, MD; Chair, OPHPR BSC

No public comments.

Meeting Recap, Evaluation, & Action Items

Thomas Inglesby, MD; Chair, OPHPR BSC

Dr. Inglesby provided a short list of action items for the BSC. They are as follows:

1. Review the agenda topics and send any subsequent comments to Dr. Groseclose.
2. Review the CDC response to BSC recommendations document and forward follow-up questions to Dr. Groseclose, if any.
3. Respond to the Request from DSLR regarding review of the revised PPHR capabilities document that will be coming in early March.

Dr. Inglesby thanked CDC leadership and staff for providing the time for BSC to hear the wonderful presentations. He felt it was very productive.

Samuel Groseclose, DVM, MPH; Designated Federal Official, OPHPR BSC

Ms. Dometa Ouisley will be forwarding an evaluation. Dr. Groseclose is interested in hearing any recommendations or comments on the web conference process. BSC members were asked to please respond to the evaluation.

He ended his comments by thanking all of the attendees for taking time to help OPHPR improve its programs and processes. He also thanked the staff for making the conference seamless.

Dan Sosin, MD, MPH; Acting Director, OPHPR

Dr. Sosin also joined in with word of appreciation to the BSC. The feedback and perspectives given by the Board are vital. Items that the BSC has asked of OPHPR will be worked on in the interim so they can be shared in advance and at the next BSC meeting.

With no further comments, the meeting was adjourned.

CERTIFICATION

I hereby certify that to the best of my knowledge, the foregoing minutes of the February 13, 2018 meeting of the OPHPR BSC are accurate and complete.

3/9/18



Date

Thomas V. Inglesby, MD
Chair, Board of Scientific Counselors, OPHPR

APPENDIX A: OPHPR BSC MEMBERSHIP ROSTER

DESIGNATED FEDERAL OFFICIAL

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APPENDIX B: BSC Meeting Attendance Roster, Atlanta, GA – February 13, 2018

BSC Web Conference Attendance Roster
Atlanta, GA – February 13, 2018

NAME	AFFILIATION	
Inglesby, Thomas	Chair and SGE	Present by phone
Brandeau, Margaret	SGE	Absent
Galea, Sandro	SGE	Present by phone
James, Erika	SGE	Present by phone
McKinney, Suzet	SGE	Present by phone
Mitroff, Ian	SGE	Present by phone
Pawlecki, Brent	SGE	Present by phone
Plough, Alonzo	SGE	Present by phone
Slemp, Catherine	SGE	Present by phone
Viswanath, Kasisomayajula (Vish)	SGE	Absent
Wooley, Dawn	SGE	Present by phone
Dickerson, Bradley (DHS)	Ex Officio	Present by phone
Herrmann, Jack (ASPR/HHS)	Ex Officio	Present by phone
Levine, Marissa (ASTHO)	Liaison	Present by phone
Askenazi, Michele (NACCHO)	Liaison	Present by phone
Quinlisk, Patricia (CSTE)	Liaison	Present by phone
Egan, Christina (APHL)	Liaison	Present by phone
Ritchey, Jamie (TEC)	Liaison	Present by phone
Magana, Laura (ASPPH)	Liaison	Present by phone

APPENDIX C: ACRONYMS

AAR After Action Report
AMT Anthrax Management Team
APHL Association of Public Health Laboratories
ARRA/HITECH American Recovery and Reinvestment Act/Health Information Technology for Economic and Clinical Health Act
ASPPH Association of Schools and Programs of Public Health
ASPR Assistant Secretary for Preparedness and Response (HHS)
ASTHO Association of State and Territorial Health Officers
BSAT Biological Select Agents and Toxins
BSC Board of Scientific Counselors
CDC Centers for Disease Control and Prevention
CEFO Career Epidemiology Field Officer
CSTE Council of State and Territorial Epidemiologists
DEO Division of Emergency Operations (CDC)
DHS US Department of Homeland Security
DoD Department of Defense
DOT Department of Transportation
DPHP Directors of Public Health Preparedness
DRMU Deployment Risk Mitigation Unit
DSAT Division of Select Agents and Toxins (CDC)
DSLRL Division of State and Local Readiness (CDC)
DSNS Division of Strategic National Stockpile (CDC)
EHR Electronic Health Record
ERPO Extramural Research Program Office (CDC)
ExO Ex Officio
FACA Federal Advisory Committee Act
FDCH Federal Document Clearing House
FOA Funding Opportunity Announcement
GAO Government Accountability Office
FRO Financial Resources Office (CDC)
HCW Healthcare Worker
HPA Healthcare Preparedness Activity (CDC)
HPP Hospital Preparedness Program
HHS US Department of Health and Human Services
IHR International Health Regulations
IOM Institute of Medicine
IT Information Technology
LO Learning Office (CDC)
LRN Laboratory Response Network
LRN-B Laboratory Response Network Biological
LRN-C Laboratory Response Network Chemical
MASO Management Analysis and Services Office (CDC)

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MCM Medical Countermeasure
NACCHO National Association of County and City Health Officials
NCEH National Center for Environmental Health
NCEZID National Center for Emerging and Zoonotic Infectious Disease
NCIRD National Center for Immunization and Respiratory Diseases
NIHB National Indian Health Board
NIH National Institutes for Health
OD Office of the Director
OID Office of Infectious Diseases (CDC)
OIG Office of the Inspector General
OPHPR Office of Public Health Preparedness and Response (CDC)
OPPE Office of Policy, Planning, and Evaluation (CDC)
ORR Operational Readiness Review
OSPHP Office of Science and Public Health Practice (CDC)
PAHO Pan American Health Organization
PAHPA Pandemic and All-Hazards Preparedness Act (PL 109-417)
PERRC Preparedness and Emergency Response Research Center
PHEP Public Health Emergency Preparedness
PHPR Public Health Preparedness and Response
SGE Special Government Employee
SLTT State, Local, Tribal, and Territorial
TEC Tribal Epidemiological Center
TFAH Trust for America's Health