



## Minutes from the October 25, 2012

### CDC Advisory Committee to the Director

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**Advisory Committee to the Director  
Record of the October 25, 2012 Meeting**

The Centers for Disease Control and Prevention (CDC) convened a meeting of its Advisory Committee to the Director (ACD) on October 25, 2012, via teleconference. The agenda included reports from the Ethics Subcommittee; the Global Workgroup (GWG); the State, Tribal, Local, and Territorial (STLT) Workgroup; and the Surveillance and Epidemiology Workgroup.

**Welcome and Introductions**

At 2:03 p.m., Ms. Gayle Hickman (Committee Specialist, Advisory Committee to the Director, Advance Team, Office of the Chief of Staff, Office of the Director, Centers for Disease Control and Prevention) called roll of ACD members present via teleconference and Envision. Ms. Hickman established that a quorum was present. Other attendees introduced themselves. A list of the meeting participants is provided with this document as Attachment 1.

Dr. Alan Greenberg (ACD Chair) asked ACD members to declare any conflicts of interest. The conflicts were as follows:

- Dr. Greenberg's department receives indirect CDC funding through the Elizabeth Glaser Foundation, the Association of Public Health Laboratories (APHL), and the District of Columbia (DC) Department of Health.
- Dr. Georges Benjamin's employer, the American Public Health Association (APHA), receives CDC funding.
- Dr. Nisha Botchwey receives CDC funds through the National Network of Public Health Institutes (NNPHI).
- Dr. Lynn Goldman reported that George Washington University receives CDC funding in addition to the funds declared by Dr. Greenberg.
- Dr. Tom Farley receives a variety of CDC grants.
- Dr. David Fleming receives a variety of CDC grants.
- Dr. Dileep Bal receives occasional funding from CDC.
- Dr. Herminia Palacio declared the receipt of indirect funding from CDC via state health departments.

**Director's Update and Discussion**

Dr. Thomas R. Frieden (CDC Director) described challenges, progress, priorities, and updates on "hot topics" at CDC.

Because of the upcoming election, there are uncertainties about the political process. Additionally, debates regarding the role of government are on-going. The infectious



disease infrastructure in the US is challenged, as there are 45,000 fewer jobs in state and local public health agencies. Many states are challenged to maintain their laboratory services. As CDC addresses noncommunicable diseases, the challenges include interest groups that are threatened by some proposed public health actions and questions of the efficacy of the proposed programs. CDC's state budget authority has been reduced by 12% in Fiscal Year (FY) 2012, and an additional 8% reduction is proposed in FY 2013. The reduction in the Prevention and Public Health Fund in 2014 will be \$250 million, and that reduction has not yet been allocated.

CDC is able to address these challenges by focusing on efficiency and impact. The agency has reduced administrative expenses by approximately \$160 million by working more efficiently and by eliminating less-essential elements. CDC has shown the cost-effectiveness of its programs. For example, the immunization program has documented that for each annual cohort that is vaccinated, approximately 20 million diseases are prevented and 40,000 lives are saved. Every dollar that is invested in immunization results in saving approximately \$3 in healthcare costs and \$10 in overall societal costs. The total savings is \$13 billion per year in healthcare costs and nearly \$70 million in total societal costs.

CDC has made progress in several areas. Within surveillance and epidemiology systems, CDC is collecting more geographically-specific, healthcare-related, and timely information. CDC can track and provide information to states about a range of trends.

The expansion of the Public Health Associate (PHA) program has been successful. After the two-year program concludes, graduates remain at local health departments or work at CDC or another public health entity. While the program had 10 PHAs in 2007, it now has 159. The program is in 34 states. Of the 2010 graduates of the program, 92% remained in public health. The PHA program is important to build the next generation of public health leaders. The program receives about 10 times as many applicants as slots are available, and about twice as many placement requests as associates are placed.

CDC heeded ACD's recommendations regarding optimizing the grants process and adopted all of the recommendations possible. The agency is restricted in some areas by Congressional mandates or legal or governmental restrictions, but CDC has worked to make resources more flexible and effective. A standardized Funding Opportunity Announcement (FOA) will greatly reduce workload and will be more consistent and clearer. Direct and technical assistance to state and local agencies is increasing. CDC has imbedded more than 500 staff in every state and in many territories.

CDC continues to work in global health. The agency works intensively to detect and stop outbreaks. Currently, a team from CDC is en route to Uganda to address a cluster of Marburg, an Ebola-like virus. The President's Emergency Plan for AIDS Relief (PEPFAR) has shown excellent results. More than 4.5 million people are on treatment for HIV, and more than 200,000 babies were born without HIV last year because of the work of the PEPFAR program. The program has come in under budget and ahead of schedule, and has been able to strengthen systems. They have worked with the African Society for Laboratory Medicine (ASLM) and national laboratory strengthening work, as



well as the Field Epidemiology Training Program (FETP). There has been an encouraging scale-up of voluntary medical male circumcision, which will be very important for HIV/AIDS prevention in Africa.

Dr. Kevin De Cock, former Director of CDC's Center for Global Health (CGH), has transitioned to Kenya. Dr. Anne Schuchat is serving as the Acting Director for CGH. CDC will conduct an internal and external search, including national and international candidates. With input from the Global Workgroup (GWG) of ACD, CGH created a global health strategy with four core goals: health impact, health security, health capacity, and organizational capacity. That strategy is informing the direction of the center.

CGH has also completed its organizational review process. All new entities created as part of the organizational improvement process three years ago will undergo this review. The review concluded that creating CGH was the right move at the right time. The center has a sound structure and is moving in the right direction, with an outstanding scope of work and no major gaps. The review identified areas for strengthening, such as coordination and communication to maintain a "One CDC" approach. Other opportunities for growth include improving communication with global partners and engagement and management of operational practices. CGH's review was extensive. It was based on more than 50 in-depth interviews, focus groups, and surveys answered by nearly 700 CDC staff from the center and from other areas.

CDC has an important role in research and development. CDC is developing and testing a series of vaccines, and is involved in improving diagnostics in both high-level reference laboratories and at point-of-care. These activities are important and would not be conducted by anyone else. When it is possible, CDC works with industry for commercialization and licensing.

An important priority for CDC, both domestically and globally, is to continue to improve the ability to detect and respond to threats. The number of multi-state foodborne disease outbreaks has increased over the past decade. Globalization and industrialization of the food supply and the improved ability to detect outbreaks means that more outbreaks are detected. As more clinical laboratories move to culture-independent tests, such as dipsticks for gonorrhea, they risk losing the ability to monitor trends in drug resistance and to track clusters that are apparent through DNA fingerprinting. A Blue Ribbon Panel was convened on this issue, and the report was concerning. Among the conclusions of the panel was that there are junior colleges with more advanced bioinformatics capacity than CDC. The volume of information available as thousands of organisms are sequenced is difficult to manage. Many gaps are in human resources.



Another CDC priority is global disease detection, global health security, and working in partnership with countries to improve their detection and response capacities to help them meet their International Health Regulations (IHR) requirements.

CDC is also working on managing the public health – clinical interface and other issues associated with the Affordable Care Act (ACA). This challenge will be significant for public health in the coming decades. How can public health and the clinical realm work together to make progress through community interventions and clinical interventions? How can the two groups work together to solve iatrogenic problems, such as prescription opiate overdose, or to improve the performance of the healthcare system for diagnosis and management of diseases and conditions?

CDC activated its Emergency Operations Center (EOC) in response to the fungal meningitis outbreak. The outbreak is large and complicated. CDC's fungal unit and fungal laboratory have strong detection capabilities. They have conducted training with state laboratories. The state laboratory of Virginia received training in 2005 and made the initial diagnosis of *Exserohilum rostratum*. CDC has worked closely with states to improve their capacity for addressing healthcare-associated infections (HAIs). Tennessee has done an excellent job of identifying and characterizing the outbreak rapidly. CDC has provided assistance to Tennessee in the past to help build their infrastructure. Over 100 CDC staff members are working on this outbreak. Treatment recommendations are updated frequently, in coordination with treatment experts, and the information is disseminated widely. This outbreak is unprecedented, and it is critical to share information quickly. Interest from the media and the clinical community has been strong.

The effort to eradicate polio is progressing. India has gone 18 months without a new case and has “gotten over the finish line.” They are potentially susceptible to the virus being reintroduced from elsewhere, but India has brought energy to eradication efforts elsewhere. Since CDC activated the EOC for polio eradication in 2011, the agency's field presence in polio has tripled. They have expanded laboratory work and increased support for partner organizations. There has been a dramatic reduction in new introductions. There were 9 new outbreaks in 2011 and no new outbreaks in 2012. Chad has only had five cases in 2012 and has not had a new case in several months. There has been a decrease in the number of infections in Afghanistan and that government is committed to the effort. The government of Pakistan is also committed to the effort, and there has been a decrease in new cases there as well. Pakistan has had encouraging trends in vaccination campaigns. Areas of Pakistan are not accessible, there are many refusals, and there are security concerns for workers, which pose challenges. State and local governments in Nigeria are working to improve systems not just for polio, but for disease control in general. There have not been dramatic improvements in outcomes in Nigeria, but there have been improvements in commitment and in the information systems that will allow for future improvement. Security is also a concern in Nigeria.



In summary, Dr. Frieden noted that CDC has made a great deal of progress and faces a number of challenges. He expressed his confidence in the superb CDC senior leadership and at every level of the organization, where personnel are mission-driven, expert, and hardworking. He said that he is honored to be part of the agency, and to lead it.

### **Discussion Points**

Dr. Tom Farley asked about CDC's contingency plans in the event of sequestration.

Dr. Frieden answered that sequestration is unlikely. While significant discretionary budget cuts may occur, it is unclear how or when. CDC has considered how to make these cuts and mitigate their damage. Every one of CDC's programs exists because it helps someone, so this task is difficult. In the event of these cuts, each center, division, and branch in CDC will determine how to preserve its essential functions with minimal damage. There is a sense in Washington that the root of the country's budget problems is not discretionary spending; rather, the basic fiscal problem stems from Medicare and revenues. The budget gap is so large that it would remain even if discretionary spending were eliminated. CDC will make clear what could be lost if budgets are cut. For example, without CDC's world-class fungal identification laboratory, the meningitis outbreak response would not have been supported effectively. It is important to make these points to reduce the likelihood of "Draconian reductions." There will be challenges, and all CDC programs are considering ways to work smarter and mitigate damage.

Sherri Berger, MSPH (Chief Operating Officer, CDC) added that as they are at the beginning of a new fiscal year, CDC is being cautious with its internal spending and its external expenditures. There are restrictions from the Office of Management and Budget (OMB) regarding how much funds can be obligated.

### **Ethics Subcommittee Update and Discussion**

Ruth Gaare Bernheim, JD, MPH (Chair, Ethics Subcommittee) greeted the ACD and acknowledged the important contributions of the two ACD representatives to the Ethics Subcommittee, Dr. George Isham and Ms. Sara Rosenbaum. She also thanked Dr. Drue Barrett, the Designated Federal Officer (DFO) of the Ethics Subcommittee.

The Ethics Subcommittee has been active. Most of their work focuses on how best to provide support to state and local health departments as they address ethical issues in practice. The work includes developing cases for training public health officials about public health ethics; developing recommendations regarding approaches for enhancing collaboration between public health ethics and public health law; developing ethics recommendations regarding use of public health travel restriction tools; and developing a framework for evaluating the impact of public health ethics.



The Ethics Subcommittee has finalized a case on mandatory influenza for healthcare providers. That case was provided for the ACD's review. The Subcommittee is in the process of developing a case to address the new ACA requirement that hospitals engage public health officials in community health needs assessments (CHNA). Additionally, the Ethics Subcommittee created a set of general recommendations regarding how to enhance collaboration between public health law and public health ethics, and an outline for a specific recommendation for developing a framework document describing how best the two fields can collaborate to better support public health officials in practice.

The Case Development Workgroup of the Ethics Subcommittee met three times in FY 2012. In addition, individual members of the Ethics Subcommittee have collaborated with members of CDC's Public Health Ethics Unit within the Office of the Associate Director for Science (OADS) to develop public health ethics training materials. This work has resulted in the development of a student and facilitator manual, and over 100 health professionals have been trained through workshops offered at recent meetings of the National Association of County and City Health Officials (NACCHO), the National Association of Local Boards of Health (NALBOH), and the Public Health Law Conference. Several individual members of the Ethics Subcommittee have assisted with this training. The training development was informed by conversations with state and local health officials about some of their most common ethics challenges.

The Ethics Subcommittee has developed cases that provide realistic, practical examples of how ethical analysis can be used to help think through public health decision-making. The cases include relevant background scientific information, a realistic case scenario that focuses on an issue that a local health director is likely to face, and questions to elicit a discussion about the ethical challenges inherent in a case. They also include a scenario shift, which allows for discussion about how contextual factors impact decision-making. The Ethics Subcommittee has also developed information that will be useful to health department officials who have an interest in public health ethics, but who may have limited experience in the process of ethical analysis. They can use the information in their health departments to begin a dialogue about the cases with members of their staff. The facilitator information includes additional questions to stimulate discussion and analysis, points to consider, and a sample ethical analysis.

Ms. Bernheim presented ACD with the Ethics Subcommittee's first completed case. In the case, a local health director is asked to provide input on whether a mandatory influenza vaccine policy should be implemented at a nursing facility.

Based on input from Ms. Rosenbaum and Dr. Isham, the Ethics Subcommittee is developing a case to address how public health and hospital systems can best work together to address new requirements in the ACA. The ACA requires that not-for-profit hospitals seek public health input in conducting CHNAs. The case illustrates how public health ethics principles and community values can be incorporated into the needs assessment process and the subsequent setting of priorities about the use of resources to improve outcomes for particular communities. The Ethics Subcommittee has completed a draft of the case and is developing the facilitator information. The topic is of



interest to state and local officials and will be useful as they think about how to interact with health systems.

The Ethics Subcommittee also has draft cases addressing other public health topics. They will prioritize the topics that resonate with state and local health officials. Further, Dr. Frieden has indicated interest in developing a case on the integration of clinical care and public health, focusing on the ethical implications of how public health can address clinical issues identified through public health data collection.

In its discussions with state and local public health officials, the Ethics Subcommittee often hears that when ethical issues arise in practice, the officials first consult a lawyer. The subcommittee has discussed ways to improve collaboration between public health ethics and public health law. The Public Health Law Collaboration Workgroup of the Ethics Subcommittee has met four times in 2012. The Ethics Subcommittee created four general recommendations in this area that highlight the importance of CDC continuing the work that has already started offering training in public health ethics to local health officials and other public health professionals. A very successful example of this work was a pre-conference workshop offered to attendees of the Public Health Law Conference. This workshop was filled to capacity, and participants were thoroughly engaged. The Ethics Subcommittee also recommends developing a framework document to make a clear case for the importance of enhancing collaboration between public health law and ethics. Other potential areas of collaboration should be explored, including strengthening ethics standards as part of the health department accreditation process. That work fits with on-going work regarding how to evaluate the impact of public health ethics.

The suggested outline for the document begins with a brief introduction to the fields of public health law and public health ethics. It describes similarities and differences in the two fields, and describes how law and ethics can best work together to support public health officials in practice and how to proceed when the law does not provide adequate direction. The document will also include cases to illustrate how to apply both the legal and ethical analysis framework.

### **Discussion Points**

Dr. Isham serves as one of the two ACD representatives on the Ethics Subcommittee and has been very actively engaged in the subcommittee's activities. He noted that the discussion has been active, and the cases will be very helpful as people in the field understand the issues and ethical concerns associated with them. The Ethics Subcommittee is dedicated to providing useful products, and he congratulated the subcommittee on its work. He recommended that the ACD approve the influenza case and looked forward to additional comments.

Dr. Greenberg thanked the Ethics Subcommittee for its work on developing cases. The work provides useful tools for health officials in their efforts to consider ethical issues as part of public health decision-making.



Dr. Herminia Palacio supported the approach of developing cases to work through ethical issues. On page 10 of the mandatory influenza case, the document refers to a “lack of scientific certainty” regarding benefits to nursing center residents, which “weakens the ethical justification” for mandatory vaccines. She asked for clarification on how the lack of certainty weakens the justification for vaccinating healthcare workers.

Dr. Drue Barrett (DFO, Ethics Subcommittee) said that the sentence was based on the notion that if there is mandatory action for healthcare workers, then there should be proof of impact. There is scientific uncertainty regarding the impact that vaccinating all healthcare workers would have on nursing home residents.

Dr. Palacio agreed with the thinking behind the point and withdrew her concern about it, but suggested that the sentence should be clarified, given that it was not clear whether the sentence referred to vaccinating residents or healthcare workers.

Ms. Bernheim confirmed that the Ethics Subcommittee would clarify the sentence.

Dr. Lynne Richardson said that the point is based on the idea that in the absence of clear scientific evidence of harm reduction, there is not a strong ethical justification for the mandatory vaccine. She wondered whether risk reduction is a sufficient rationale to require vaccination.

Ms. Bernheim answered that making an act mandatory requires strong data to for it to be ethically justified. She agreed that ethics justifies vaccination, but making the vaccinations mandatory requires an additional element of ethical justification. There is not clear evidence to tie mandatory healthcare worker vaccination to outcomes in nursing homes. An ethics discussion views all sides of a topic and determines how the ethical issues line up on both sides.

Dr. Richardson suggested that the case set the “ethical bar too high” in terms of the level of justification that mandatory vaccination requires. These decisions require balancing risks, harms, and benefits of all of the actors involved. Requiring scientific evidence of reduction of harm in order to fully justify a mandatory action on the part of healthcare workers may set the bar too high. Many mandatory standards for healthcare workers do not rise to that level. In the effort to present both sides, the case overstated a “weak issue.”

Ms. Bernheim appreciated the comments and understood the importance of balancing the issues and suggested that the sentence could be worded more clearly.

Dr. Greenberg asked whether the Ethics Subcommittee should recraft the case, or whether the ACD could vote on it with the understanding that the subcommittee would modify the paragraph in question.

Dr. Frieden said that there may not be a need for ACD to vote on the case. The ACD provided input and comments. The case development work of the Ethics Subcommittee is important, and the involvement of the ACD in moving it forward is valuable.



Regarding the collaboration between public health law and public health ethics, Dr. Dileep Bal said that while clarity on these issues is necessary, putting a structure on the issues could become a barrier. Public health law and public health ethics can be in conflict, such as in chronic disease control and policy intervention. Policy intervention is intrinsic to the chronic disease control effort. Structuring the collaboration between public health law and public health ethics could have a limiting effect on innovation in the field.

Ms. Bernheim clarified that the goal of the work is not to say what is ethical and what is not ethical. The Ethics Subcommittee is working with public health officials, and their goal is to develop a framework that the officials can use to think through all sides of an ethical issue and come to the best decision given the current context. The document was not intended to provide ethical answers, but was meant to raise questions that local and state officials could employ to systematically consider ethical dimensions in their decision-making.

Ms. Carmen Villar (DFO, Advisory Committee to the Director, Centers for Disease Control and Prevention) said that additional comments on the Ethics Subcommittee should be provided via email to Dr. Isham and Ms. Rosenbaum.

#### **Global Workgroup Update and Discussion**

David Fleming, MD (Global Workgroup Chair) presented the ACD with the summary of the April 25, 2012 meeting of the GWG.

#### **Motion**

The ACD unanimously approved the meeting minutes from the April 25, 2012 meeting of the Global Workgroup.

Dr. Fleming summarized the previous day's meeting of the GWG, which occurred via teleconference. Given that Dr. Greenberg transitioned to Chair of the ACD, Dr. Fleming assumed the role of Chair of GWG.

The GWG is sorry that Dr. Kevin De Cock has returned to Kenya and is no longer the director of CGH, but they are pleased that Dr. Anne Schuchat is serving as the interim director of the center. The meeting included updates from various areas of CGH, and they are "not skipping a beat" in the transition process. Of particular note are the Marburg outbreak and the implementation of the CGH strategic plan.

The GWG meeting included a review of the CGH's new communication plan. An analysis of media coverage showed that CDC and CGH are frequently in the news, but usually for disease-specific issues. Therefore, the larger strategic direction of CGH tends to be lost. The CGH communication staff developed an aggressive plan to address this issue. GWG endorsed the plan and agreed with the notion of CGH forgoing



the deeply-ingrained public health “modesty” that has characterized its communication in the past. Rather, the communication plan focuses on visibility for the center and on ways for CDC to work with a range of its partners to increase the likelihood that CDC will be mentioned as a partner in global health activities. The communication strategy includes incorporating wider global health messaging, regardless of the issue that CGH is addressing at the time.

The GWG also heard a presentation regarding the organizational review report prepared for CGH. The review was complementary of CGH’s work to date and enthusiastic about the center’s future promise. The review included recommendations that CGH is considering. GWG endorsed the findings of the review and encouraged CGH to proceed with the recommendations. GWG also suggested that given the number of recommendations in the report, CGH should prioritize and sequence them and link them to the implementation of the strategic plan. It is important to identify dedicated resources to ensure progress. GWG agreed to serve as a “watchdog” to monitor the process over time.

The GWG meeting concluded with the identification of a number of important priority items for the next in-person GWG meeting in April 2013.

#### **Discussion Points**

Dr. Greenberg said that the discussion of the rollout of CGH’s strategic plan was excellent. Dr. Pattie Simone, Principal Deputy Director of CGH, is leading the implementation strategy for the plan. The strategy includes multiple workgroups. GWG was supportive of the efforts to turn the strategic plan into a clear operational strategy.



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

Dr. Fleming (State, Tribal, Local and Territorial Workgroup Chair) said that the ACD charged its STLT Workgroup to provide recommendations to CDC on how CDC can support the evolution of “Health Departments of the Future,” recognizing great changes in public health, including healthcare reform, budget tensions, increasing polarization, and changes in mission.

During the last ACD meeting, the STLT Workgroup presented a preliminary report regarding how they had prioritized the issues. Four topic areas emerged from the workgroup’s deliberations:

- The relationship between clinical healthcare and public health
- Core services that health departments offer
- Shared services and options for regionalization, particularly for small health departments
- Workforce development needs for the future of public health

The STLT Workgroup established sub-workgroups to address each of the four topics. The sub-workgroups met via teleconference and generated specific recommendations.

#### Clinical Healthcare and Public Health Recommendation 1: Community Benefit

CDC should pay increased attention to making community benefit a reality. CDC should continue to work with the Internal Revenue Service (IRS) to make the community benefit process as useful and friendly as possible for hospitals and health departments. CDC should also provide guidance to health departments on strategies to leverage the community benefit process in their communities to the advantage of both the healthcare system and public health. There is an urgent need for leadership in this area.

#### Clinical Healthcare and Public Health Recommendation 2: Electronic Health Records

Much work remains to be done in the area of electronic health records (EHRs). CDC should continue to play a leadership role to fulfill the promise of EHRs to provide information about the health of the public. The workgroup urged CDC to develop strategies for using national industry standards for EHRs in population-based surveillance systems. CDC should also identify ways to break down the real and perceived legal barriers that clinical care systems see in sharing information with public health.

#### Clinical Healthcare and Public Health Recommendation 3: Financing Population Health

CDC should collaborate further with other US Department of Health and Human Services (HHS) entities to help realize the potential of the ACA in contributing financing and support for population-based healthcare delivery, including options for technical assistance for billing for services, including an expanded array of clinical and community prevention services.



Core Services in Public Health Recommendation 1:  
Current Practices/Thinking on Core Public Health Services

There is no nationally agreed upon standard for the core services that health departments should offer. Formative work needs to be done in this area, and the STLT Workgroup encourages CDC to gather and analyze information from across the STLT community on current practices and viewpoints regarding the need for, and the nature of, core services in public health.

Core Services in Public Health Recommendation 2: Stakeholder Process for Guidance

CDC should create a stakeholder process to provide guidance to the public health system, CDC, and STLTs on making decisions about the nature of future services and programs in public health. What should the services be, how can they best be delivered, and how can the field move to a standardized set of core, foundational services as budgets become constrained and there is increasing scrutiny from decision-makers?

Shared Services/Regionalization Recommendation 1: Shared Services Clearinghouse

The public health system includes many small health departments. The opportunity for economy of scale has not been fully realized by considering ways to share services across jurisdictions and to regionalize. CDC should establish a more robust, real-time clearinghouse of program best practices and models that demonstrate how shared services work in the field.

Shared Services/Regionalization Recommendation 2:  
Incentivize Use of Shared Services

CDC's funding to health departments should incentivize opportunities for sharing services and regionalization. Jurisdictions can be motivated to work together to optimize resources and service utilization.

Shared Services/Regionalization Recommendation 3:  
Add Value to Existing Shared Services Initiatives

Several think tanks on this issue have been developed nationally. CDC has provided support to these think tanks, and should continue to support and partner with them to better assure a common process.

Workforce Development Recommendation 1: Vital Public Health Workforce Gaps

There are vital public health workforce gaps and multiple stakeholders in the process. CDC should lead a coordinated effort to engage external and internal partners to develop a comprehensive workforce strategic plan.



Workforce Development Recommendation 2:  
Core Competencies in CDC Training Programs

CDC should potentially redesign its training programs for both internal CDC staff and external STLT workforce to include the core competencies needed in the 21<sup>st</sup> Century health department. These skills include data management and use of technology; core scientific expertise; policy support and advocacy competency; and adaptive leadership and “influencing without authority” skills.

Workforce Development Recommendation 3:  
Partnership of Public Health Workforce and Healthcare System

The promise of healthcare reform includes closer collaboration between the public health workforce and the healthcare system workforce. CDC should facilitate the ability of the public health workforce to capitalize on this opportunity. This work can include training on public health for the clinical workforce.

Workforce Development Recommendation 4:  
Realignment of Public Health School Curricula

The curricula in many schools of public health are not up-to-date. CDC should partner with schools of public health and the Association of Schools of Public Health (ASPH) to modernize the curricula. In particular, CDC should explore curricula and career paths for students obtaining Bachelor’s degrees in public health.

Dr. Fleming commended the sub-workgroups for their efforts, and noted that they endeavored to create recommendations that are concrete enough to be actionable.

**Discussion Points**

Dr. Bal referred to the recommendation on community benefit and recognized the excellent work of Dr. Judy Monroe and other CDC personnel. He said that that the CHNA process has been analyzed within CDC, and the work has been of great help to him in Hawaii. He urged CDC to disseminate the materials quickly to NACCHO and the Association of State and Territorial Health Officials (ASTHO) so that they can be used extensively.

Dr. Fleming commented on the remarkable staff support from across CDC in the development of the recommendations. Subject matter experts from throughout the agency contributed their time and expertise to the deliberations.

Dr. Isham referred to the recommendation on EHRs. The recommendation focuses on how public health acquires information from EHRs, but does not refer to how public health data will be used more effectively within healthcare. He then referred to the recommendation on financing public health that refers to providing technical assistance for billing for services. That recommendation may add to the problem of the proliferation of billing and promotion of the extension of fee-for-services, which payment reform in healthcare is moving away from.



Dr. Fleming answered that the recommendation recognizes that payment reform is occurring, but many services that public health traditionally provides are now increasingly in the interest of the clinical care system to provide or to be provided. In that context, in systems where fee-for-service billing processes still exist, it is important to determine how to make those changes work. There should be innovations in the financing mechanism so that when it is appropriate, the public health workforce should be financed to provide those services. Regarding EHRs, he agreed with Dr. Isham's point and with the work of the Institute of Medicine (IOM) on the future of public health regarding the need to use public health population data in the clinical healthcare system. The workgroup did not believe that this work is not important, but they recognized the priority of working with the healthcare system on EHR data in a timely manner.

Dr. Frieden found the recommendations to be helpful, concrete, and practical. They give the Office for State, Tribal, Local and Territorial Support (OSTLTS) "marching orders" for the next year.

Judy Monroe, MD, FAAFP (Director, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention) agreed that the recommendations were concrete and useful, and indicated that OSTLTS would move forward on the recommendations with the rest of CDC.

Dr. Frieden suggested that the STLT Workgroup continue to think about the public health – clinical interface. It will be helpful to drill down in this area, sharing lessons and identifying areas that do not work.

Dr. Tom Farley commented that in contrast to Dr. Bal's experience in Hawaii, New York City has not made progress on community benefit with area hospitals. The hospitals have not engaged in meaningful work, and do not seem inclined to change. He asked whether CDC is confident that the requirements from IRS are clear regarding how hospitals need to do things that are substantial and different in assessing community health needs and acting on them, or whether the guidance from the IRS to hospitals is vague.

Andrew Rein, MS (Associate Director for Policy, Centers for Disease Control and Prevention) said that the June 11 guidance provides more specificity than the ACA itself. Certain elements are required. The next level of specificity has not been released. The IRS has had technical questions about public health and how it works. Between the ACA and the June 11 guidance, hospitals should know that they should be taking new steps. CDC knows of success stories and examples from around the country, and they should share more of them.



Dr. Bal said that CHNA provides “both the carrot and the stick.” The hospital conglomerates in Hawaii decided to conduct a CHNA. Their process was “business as usual.” Dr. Bal read the ACA and outlined areas in which the hospitals’ process was in violation of it. The law requires systematic involvement of the public health community, but the hospitals had not done that. Additionally, the process is supposed to be grassroots, but the hospitals’ proposed process only allowed for post facto community input via a key informant survey. The IRS requirements are clear that hospitals pay for the kinds of work that the Community Transformation Grants (CTGs) and Communities Putting Prevention to Work (CPPW) require. Dr. Bal is conducting a separate CHNA using the public domain instrument that CDC has developed and that is available at <http://www.chna.org>. He observed that commercial vendors are working with lawyers and hospitals to keep this work off of the public agenda. Many hospitals are waiting, because the next report is not due for three years. There are creative ways to accomplish this work. For instance, the Mayor of New York City could recognize that the requirements of the CHNA process are not being fulfilled. If he recognizes that the public health constituency has not been involved at every level, and that the process has not been grassroots, the hospitals will be forced to act.

**Motion**

There was a motion and a second to accept the recommendations of the STLT Workgroup. The motion carried unanimously.

**Surveillance and Epidemiology Workgroup Update and Discussion**

Kelly J. Henning, MD (Surveillance and Epidemiology Workgroup Chair) presented the final report from the Surveillance and Epidemiology Workgroup to the ACD.

The workgroup sought responses to the *Morbidity and Mortality Weekly Report (MMWR)* Surveillance Supplement on Adult Clinical Preventive Services that was published on June 16, 2012. The workgroup provided advice as the supplement was being created.

On August 3, 2012, Dr. Henning sent an email to the 10 members of the Surveillance and Epidemiology Workgroup and asked them the following questions:

- Have you discussed this *MMWR* with colleagues or heard comments or responses from stakeholders? If so, what feedback have you received?
- Were there specific sections or aspects of the report that you found helpful, confusing, or problematic?
- Do you think that this report should be repeated?
- If so, what changes would you propose to CDC in terms of content and/or organization?



Five members of the workgroup responded with thoughtful and helpful comments. Regarding the first question, which was meant to assess uptake of the *MMWR* supplement, the responses suggested that there was not much discussion about the supplement. The workgroup members forwarded the supplement to their colleagues, and there was some discussion, but it was fairly minimal. Many people commented that the report, at 78 pages, was dense, with a great deal of text. The density of the report may have contributed to a lack of uptake.

Many respondents felt that the supplement is a good reference document. The material is solid, and the document is comprehensive. It is not likely that the document will be read in total, but instead will be read in pieces. When determining what to include in the report, a theme of the workgroup was the importance of adhering United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) recommendations.

All respondents to the questionnaire felt that the report should be repeated periodically for benchmarking purposes. They also felt that the plans and take-home messages were clear. Repeating those messages and assessing how they change over time will be useful.

Regarding possible changes for future reports, the respondents addressed the report's length and detail. Some respondents recommended a *Vital Signs* series on clinical preventive services. There were also suggestions about limiting the report length and promoting the report more so that more people will read it and provide feedback. The workgroup also discussed state-level data at length in its deliberations, and the respondents to the survey indicated a desire for more state-level data while recognizing that it is not always available.

Additional suggestions included graphical presentations, dashboards, and interactive infographics as means for presenting and enhancing the material. In summary, the work was appreciated.

### **Discussion Points**

Dr. Isham noted that the survey responses suggested that future reports align with the USPSTF and ACIP recommendations, and that there should be emphasis on overuse and misuse of preventive services, which are key problems.

Jim Buehler, MD (Director, Public Health Surveillance Program Office; DFO, Surveillance and Epidemiology Workgroup) thanked Dr. Henning and the workgroup for their contributions. The workgroup is scheduled to be sunsetted because it was developed specifically to provide guidance on the report. He thinks that there is tremendous value in having a Surveillance and Epidemiology Workgroup of the ACD, and the group could be reconstituted to address a number of issues in the future. For instance, the workgroup could address the recommendation from the STLT Workgroup regarding using EHRs and improving capacity to meet the needs for information about the health of populations.



Dr. Frieden said that the STLT Workgroup has been very helpful in assessing CDC's current trajectory and suggesting ways to work differently. The GWG is giving similar guidance and direction. Between now and the next ACD meeting, they could think of how best to involve the ACD in the area of surveillance, epidemiology, and laboratory services.

Stephen Thacker, MS, MSc (Director, Office of Surveillance, Epidemiology and Laboratory Services, Centers for Disease Control and Prevention) agreed and added that surveillance, epidemiology, and laboratory services are essential functions of CDC. They may have an opportunity to make significant changes, because many states are willing and anxious to work together on many activities. They should be poised to work across states on activities.

Regarding partnering with the private sector, Dr. Isham commented that the government can contribute to the promulgation of consistent standards. The private sector sometimes hears different signals from the Centers for Medicare and Medicaid Services (CMS) and CDC on standards. There is an opportunity in the surveillance work to send a clear message by standardizing on the USPSTF and ACIP recommendations. He suggested that the STLT Workgroup think about how the government could partner and make tangible steps toward sharing government data easily.

Dr. Greenberg thanked Dr. Henning for her service as chair of the Surveillance and Epidemiology Workgroup, and thanked the rest of the workgroup members. He highlighted the suggestion that Dr. Frieden consider reconstitution of another version of this workgroup in the future.

#### **Public Comment**

At 3:51 p.m., Dr. Greenberg opened the floor and invited public comment. No public comments were offered during this ACD meeting.

#### **Closing Comments**

Dr. Frieden asked for the ACD's feedback on the "virtual" format of the meeting.

Dr. Isham commented that the ethics portion of the agenda was not served well by the meeting format. Because of the time compression and the complexity of the discussion, the topic did not receive the conversation that it deserved. They would be better served if they had access to PowerPoint or other video conferencing software that is computer-based. For instance, the Web-X format allows for better control, audio quality, and the ability to use other materials. The Ethics Subcommittee's work was not well-served by the technical difficulties.

Dr. Lynn Goldman supported the idea of meeting virtually, but said that this meeting did not always work well technologically.

Dr. Farley said that solving the technology problems is important, and meeting virtually is easier than convening personally in Atlanta.



## Advisory Committee to the Director: Record of the October 25, 2012 Meeting

Dr. Richardson appreciated the need to save money and time, but noted that the technological interruptions were disruptive. She suggested that they explore more reliable technology and allow for sharing materials and presentations. She did not think that a two-hour timeframe was sufficient.

Dr. Greenberg agreed that two hours was not adequate for meaningful discussion on the workgroup reports.

Dr. Bal agreed. He suggested that the ACD could provide guidance on ways that CDC can help public health in new ways, such as with technical assistance and the CHNA. The CHNA is a great opportunity, if it is used properly. For instance, one of the IRS provisions addresses community benefits and community-building. Community-building includes the upstream prevention that CDC does. If communities define their priorities, then hospitals must find ways to address those priorities. CDC's tools should be disseminated quickly.

Dr. Frieden thanked the ACD members for their valuable input, and encouraged them to continue to provide feedback on an on-going basis. He pointed out that there was recent media coverage on allegations regarding lack of safety at one of CDC's laboratory buildings at the Clifton Road campus. An external committee from Canada conducted an extensive on-site review. They offered some recommendations, but were overall impressed with the level of safety and security at CDC's laboratories. He apologized for the technical difficulties and said that they would follow up to make improvements.

With no further business posed or additional comments / questions raised, Dr. Greenberg thanked ACD and adjourned the meeting at 4:01 p.m.



## Advisory Committee to the Director: Record of the October 25, 2012 Meeting

### Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 25, 2012, meeting of the Advisory Committee to the Director, CDC are accurate and complete.

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Date

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Alan E. Greenberg, MD, MPH  
Chair, Advisory Committee to the  
Director, CDC



**Attachment #1: Attendance**

**ACD Members Present:**

**Dileep G. Bal, MD, MS, MPH**

Kauai District Health Officer  
Island of Kauai, Hawaii

**Georges C. Benjamin, MD, FACP, FNAPA, FACEP(E), Hon FRSPH**

Executive Director  
American Public Health Association

**Nisha D. Botchwey, PhD, MCRP, MPH**

Associate Professor  
School of City and Regional Planning  
Georgia Institute of Technology

**Benjamin K. Chu, MD, MPH, MCAP**

Group President, Kaiser Permanente Southern California and Hawaii  
President, Permanente Southern California Region

**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, Global Workgroup, ACD  
Chair, State, Tribal, Local and Territorial Workgroup, ACD

**Lynn R. Goldman, MD, MS, MPH**

Dean, School of Public Health and Health Services  
Professor of Environmental and Occupational Health  
George Washington University

**Alan E. Greenberg, MD, MPH**

Professor and Chair  
Department of Epidemiology and Biostatistics  
George Washington University School of Public Health and Health Sciences  
Chair, Advisory Committee to the Director, CDC

**Kelly J. Henning, MD**

Director, International Health Programs  
Bloomberg Foundation  
Chair, Epidemiology and Surveillance Workgroup, ACD



**George J. Isham, MD, MS**

Chief Health Officer  
HealthPartners Incorporated

**Anthony B. Iton, MD, JD, MPH**

Senior Vice President, Healthy Communities  
The California Endowment

**Herminia Palacio, MD, MPH**

Executive Director  
Harris County Public Health and Environmental Services

**Lynne D. Richardson, MD, FACEP**

Professor and Vice Chair of Emergency Medicine  
Professor of Health Evidence and Policy  
Mount Sinai School of Medicine  
Chair, Health Disparities Subcommittee, ACD

**ACD Members Absent:**

**Sylvia Drew Ivie, JD**

Former Senior Deputy for Human Services and Development  
Office of Supervisor Mark Ridley-Thomas  
LA County Board of Supervisors, Second District

**Sara Rosenbaum, JD**

Harold and Jane Hirsh Professor and Founding Chair of the Department of Health Policy  
George Washington University  
Chair, Policy Workgroup, ACD

**CDC Staff Attending:**

**Ileana Arias, PhD**

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

**Valerie D. Bampoe, MPH**

Public Health Prevention Service Fellow  
Office of the Associate Director for Program  
Office of Surveillance, Epidemiology, and Laboratory Services

**Drue H. Barrett, PhD, CAPT, USPHS**

Public Health Ethics Coordinator  
Office of the Chief Science Officer  
Office of the Director  
Designated Federal Officer, Ethics Subcommittee, ACD



**Sherri A. Berger, MSPH**  
Chief Operating Officer  
Office of the Director, CDC

**Coleen A. Boyle, PhD, MSHyg**  
Director  
National Center on Birth Defects and Developmental Disabilities

**James (Jim) W. Buehler, MD**  
Director, Public Health Surveillance Program Office  
Office of Surveillance, Epidemiology, and Laboratory Services  
Designated Federal Officer, Surveillance and Epidemiology Workgroup, ACD

**Kathleen Ethier, BA, PhD**  
on behalf of  
**Janet Collins, PhD**  
Associate Director for Program  
Office of the Director

**Katherine Lyon Daniel, BA, PhD**  
Associate Director for Communication  
Office of the Director, CDC  
Designated Federal Officer, Communications Workgroup, ACD

**Kimberly Dills, MPH**  
Special Assistant to the CDC Director  
Advance Team  
Office of the Chief of Staff  
Office of the Director, CDC

**Heather Duncan, BS, MPH**  
Deputy Chief of Staff  
Office of the Chief of Staff  
Office of the Director

**Thomas R. Frieden, MD, MPH**  
Director, CDC  
Administrator, ATSDR

**Gayle J. Hickman**  
Committee Specialist, Advisory Committee to the Director  
Advance Team  
Office of the Chief of Staff  
Office of the Director, CDC



**Robin Ikeda, MD, MPH, CAPT, USPHS**

Director

Office of Noncommunicable Diseases, Injury and Environmental Health

**Harold W. Jaffe, MD, MA**

Associate Director for Science

**Rima Khabbaz, MD**

Director

Office of Infectious Diseases

**Leandris Liburd, PhD, MPH, MA**

Director

Office of Minority Health and Health Equity

Designated Federal Officer, Health Disparities Subcommittee, ACD

**Judith (Judy) Lipshutz, MPH**

Public Health Analyst

Office of the Director

Office for State, Tribal, Local, and Territorial Support

**Jennifer Meunier, BS, MPH**

Special Assistant to the Principal Deputy Director

Office of the Chief of Staff

Office of the Director, CDC

**Judith (Judy) A. Monroe, MD, FAAFP**

Director, Office for State, Tribal, Local, and Territorial Support

Designated Federal Officer, State, Tribal, Local, and Territorial Workgroup, ACD

**Andrew S. Rein, MS**

Associate Director for Policy

Office of the Associate Director for Policy

Office of the Director, CDC

Designated Federal Officer, Policy Workgroup, ACD

**Anne Schuchat, MD, RADM, USPHS**

Acting Director

Center for Global Health

Acting Designated Federal Officer, Global Workgroup, ACD

**Pattie Simone, MD, CAPT, USPHS**

Principal Deputy Director

Center for Global Health



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

Director  
Office of Surveillance, Epidemiology, and Laboratory Services

**Carmen Villar, MSW**

Chief of Staff  
Designated Federal Officer, Advisory Committee to the Director  
Office of the Chief of Staff  
Office of the Director, CDC

**Agnes Warner, MPA**

Special Assistant to the CDC Director  
Advance Team  
Office of the Chief of Staff  
Office of the Director, CDC

**General Public:**

**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, ACD

**Kendra Cox, MA**

Writer/Editor, Senior Technical Writing Lead  
Cambridge Communications & Training Institute

**Lauren Hanen**

Chief of Government and Public Affairs  
National Association of County and City Health Officials

**Dee Dee Honaman**

Associate Vice President for Advancement  
CDC Foundation

**Christine Jamieson**

American Psychological Association

**Verla Neslund, JD**

Vice President for Programs  
CDC Foundation

**Ann E. O'Connor, MPA**

Public Health Advisor  
Office of the Associate Director for Program



**Chloe Knight Tonney**  
Senior Vice President for External Affairs  
CDC Foundation



**Attachment #2: Acronyms Used in this Document**

Acronym	Expansion
ACA	Affordable Care Act
ACD	Advisory Committee to the Director
ACIP	Advisory Committee on Immunization Practices
APHA	American Public Health Association
APHL	Association of Public Health Laboratories
ASLM	African Society for Laboratory Medicine
ASPH	Association of Schools of Public Health
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health
CHNA	Community Health Needs Assessment
CMS	Center for Medicare and Medicaid Services
CPPW	Communities Putting Prevention to Work
CTG	Community Transformation Grant
DC	District of Columbia
DFO	Designated Federal Officer
EHR	Electronic Health Record
EOC	Emergency Operations Center
FETP	Field Epidemiology Training Program
FOA	Funding Opportunity Announcement
FY	Fiscal Year
GWG	Global Work Group
HAI	Healthcare-Associated Infection
HHS	United States Department of Health and Human Services
IHR	International Health Regulations
IOM	Institute of Medicine
IRS	Internal Revenue Service
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
NACCHO	National Association of County and City Health Officials
NALBOH	National Association of Local Boards of Health
NNPHI	National Network of Public Health Institutes
OADS	Office of the Associate Director for Science
OMB	Office of Management and Budget
OSTLTS	Office of State, Territorial and Tribal Support
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	Public Health Associate
STLT	State, Local, Tribal, and Territorial
USPSTF	United States Preventive Services Task Force

