

Office of Public Health Preparedness and Response (OPHPR)
Board of Scientific Counselors (BSC) Web Conference
Thursday, August 30, 2018, 2 – 5 PM EST
Atlanta, Georgia

Table of Contents

Roll Call, Review of Federal Advisory Committee Rules, Duties, and Conflict of Interest..... 3

Welcome, Call to Order, Introductions, and Opening Remarks 4

OPHPR Update 4

OPHPR Update - continued..... 5

DSLRL Status Report: Operational Readiness Review 6

DSLRL Status Report - continued 7

Recommendations/Comments from the BSC to DSLRL: 10

Vulnerable Populations and Emergency Preparedness and Response 10

Vulnerable Populations and Emergency Preparedness and Response - continued 12

Recommendations/Comments from the BSC:..... 13

BSC Member Discussion..... 14

Public Comment Period 15

Meeting Recap/Meeting Adjourn 15

CERTIFICATION..... 16

APPENDIX A: OPHPR BSC MEMBERSHIP ROSTER..... 18

APPENDIX B: BSC Meeting Attendance Roster, Atlanta, GA – August 30, 2018..... 21

APPENDIX C: ACRONYMS 22

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

Samuel Groseclose, DVM, MPH; Associate Director for Science, Dr. Groseclose began the meeting by thanking all the participants of the web conference. He then introduced the BSC's new Designated Federal Official, Dr. Kimberly Lochner. The BSC also welcomed a new BSC Coordinator, Ms. Rebecca Hall.

Kimberly Lochner, ScD, Deputy Associate, Director for Science, OPHPR and Designated Federal Official, OPHPR BSC

Roll call was conducted. Quorum was present.

Quorum must be maintained, and members must be present during any voting periods; therefore, members were asked to notify Dr. Lochner before leaving portions of the meeting to ensure that quorum is maintained.

Dr. Lochner updated the BSC on membership changes. Dr. Sally Phillips, Deputy Assistant Secretary for the Office of Incident Command and Control, Office of Strategy, Policy, Planning and Requirements at the Office of the Assistant Secretary for Preparedness and Response (ASPR), is returning to the board as an Ex Officio member, replacing Mr. Jack Herrmann. Dr. Anthony Macintyre, Senior Medical Advisor for Federal Emergency Management Agency (FEMA), is representing the Department of Homeland Security as an Ex Officio member, replacing Dr. Bradley Dickerson. Dr. John Dreyzehner, Commissioner of Health for the State of Tennessee is serving as the Primary Designated Liaison Member to the BSC for Association of State and Territorial Health Officials (ASTHO). Mr. Jim Blumenstock is continuing to serve as the first alternate and Gerrit Bakker, the second alternate, from ASTHO. Lastly, Drs. Dawn Wooley and Suzet McKinney's re-nominations to the BSC board have been approved by the Secretary of HHS but remain unofficial pending completion of the reapproval of special government employees by CDC's Human Resources Office. They are anticipated to be active members by the Fall in-person BSC meeting.

The meeting was led by Dr. Inglesby, the Chair. Discussions and deliberations were among BSC Members, Ex Officio Members, and Liaison Representatives. The public was allowed to comment during the Public Comment portion of the agenda only. All speakers were asked to identify themselves and all participants agreed to have their comments monitored and recorded.

Dr. Lochner reviewed the BSC responsibilities as per its charter, as well as conflict of interest waivers. All Confidential Financial Disclosure Report Update Forms should have been completed and returned to Dr. Lochner prior to the meeting, if there have been any changes made since last submitted. Members were asked to identify any conflicts of interest. Dr. Inglesby is working on two projects that are funded by CDC for resilience and risk communication, as previously reported. Dr. Cathy Slemph is a consultant on one project funded by OPHPR (one of the projects cited by Dr. Inglesby). These projects are not the subject of BSC discussions.

Welcome, Call to Order, Introductions, and Opening Remarks

Thomas Inglesby, MD; Chair, OPHPR BSC

Dr. Inglesby thanked the OPHPR leads and staff for setting up the web conference, which he felt was the most substantive phone meeting the BSC has held thus far. The amount of effort directed to make the web conference possible shows the value that CDC places on the BSC. Committees that are fortunate to have engaged federal agencies and membership are the most constructive. He was extremely impressed with the agenda and asked all BSC members to contribute their valued advice.

OPHPR Update

RADM Stephen C. Redd, MD, Director, OPHPR

Dr. Redd covered four specific topics: the convening of a Senior Leader Response Group; transition of the Strategic National Stockpile; the upcoming flu exercise; and some ongoing response work that required CDC participation.

The Senior Leader Response Group is a meeting of CDC Center/Institute/Office (CIO) senior leaders to improve OPHPR coordination across CDC. This group allows leaders to share information and gain advice, which will ultimately build a stronger response team across CDC. Some of the topics addressed to-date include improving surveillance for medical system stress during influenza pandemics; ways to triage information received by the Operation Center more effectively; usage of the Emergency Response Operations Workgroups to improve overall response; and a data preparedness effort that will leverage information management, techniques, surveillance work, and products from programs.

CDC's support of the National Biodefense Strategy (NBS) is an element the Senior Leader Response Group has undertaken. The Strategy is part of the National Defense Authorization Act called for in December 2016, with a report due at the end of September 2017. The report addresses a broad, across-government set of activities. OPHPR is working with CDC leaders to construct ways to interface with the NBS coordination team that will lead the implementation work. Although all the details are not clear, it is anticipated that there will be data calls and workgroups. The Senior Leader Response Group will ensure that CDC works in a unified fashion.

The transfer of the Strategic National Stockpile from CDC to ASPR was a decision made public at the time of the President's budget release in early February of 2018. Five workgroups were formed between OPHPR and ASPR to ensure a seamless transfer and that the mission of stockpile is not compromised. The workgroups addressed budget, contracting, communications, subject matter expertise at CDC, and work at the state and local level. The efforts of the workgroups covering budget, contracting, and communications have flowed well. The goal of the subject matter expertise (SME) workgroup is to ensure the SMEs at CDC remain connected to the work of the stockpile and the overall HHS medical countermeasure mission, which is now completely under ASPR. This effort has also gone well. There are some matters still being resolved by the state and local level workgroup, particularly related to CDC's long-term connection with state and local health departments. CDC's opinion is that closer

alignment among all parties will cause greater effectiveness of the stockpile. Deliberation continues in that regard.

OPHPR Update - continued

An influenza exercise will be conducted September 12-14, 2018. This is the 8th functional flu exercise. There has not been a functional exercise since September of 2012 due to the taxing responses of Ebola and Zika. The scenario is day 35 of a notional H7N9 outbreak first recognized among travelers to China; thousands of cases have been reported; and decisions have been made to distribute pre-pandemic vaccine from the Stockpile even though it's not well matched to the H7N9 virus. The exercise will focus on decision making by creating an environment of working under pressure while managing a torrent of information flowing in and demands for information dissemination. Engagement will be inside and outside of the U.S. government, including representatives from eight state or local jurisdictions.

A two-hour anthrax tabletop was also convened in June 2018. The purposes of the tabletop were to familiarize Dr. Redfield, CDC's newly appointed Director, on his role in an anthrax event, demonstrate CDC's capabilities, and to exercise CDC's roles and responsibilities in this type of response.

CDC continues to be involved in some public health responses. Other than for polio eradication, the CDC EOC is not activated, but it is playing a supporting role in a number of response activities. OPHPR is part of an interagency group, whose goal is reduce the burden of the opioid epidemic. A number of state health departments have activated their emergency operation centers to address the epidemic. OPHPR is providing advice and technical assistance to the Injury Center regarding incident management structure, manpower needs, and how to shorten the timeline of moving funding through CDC using the Supplemental Crisis Notice of Funding Opportunity.

Fifteen cases of wild-type polio have been reported in 2018. Twelve of those are in Afghanistan and three in Pakistan. OPHPR continues to support the work of the Polio Response Group on issues such as travel, training, emergency operation centers, and logistics. The Polio Containment Group is anticipated to have increasing responsibilities as OPHPR moves further into polio eradication. Work completed thus far includes surveys to identify facilities that have polio virus in their collections and will hold the virus after eradication. This is a complicated initiative that will be under the World Health Organization's leadership.

OPHPR is also working on the hepatitis A outbreaks. The National Center for Hepatitis, HIV, and STD Prevention (NCHHSTP) is the lead center for this response. Over 5,000 cases that have occurred in ten states. OPHPR has engaged with the PHEP directors to make connections to their jurisdiction's vaccination and hepatitis control programs and ensure resources are available to state health departments. There's been some internal technical assistance with the NCHHSTP on its structure to respond to these challenging outbreaks.

CDC has been tracking the Ebola outbreak in the eastern Democratic Republic of Congo. This is the 10th outbreak in the Congo. There are currently 115 cases. The outbreak is challenging due to the armed conflict that is occurring in the same area. The conflict is causing security issues and impeding the public

health response. The outbreak began at the peak of the outbreak in the northwestern Democratic Republic of Congo and went undetected for several months. A significant number of deaths have occurred. Healthcare workers also have been affected. The main challenge is getting staff, whether expatriate or locally employed, to perform the work. A vaccination for Ebola is now available; if responders can identify contacts, secondary cases can be prevented rather than the standard approach of observing contacts and placing them in isolation to see if they convert to confirmed cases. There are a number of CDC and field epidemiology trained staff that are participating in this response. Public Health Emergency Management Fellowship graduates are also a part of the response.

OPHPR is looking forward to the future. There's a lot of work that still needs to be undertaken to improve preparedness and the office is doing all that it can to aid others in an effective response.

Dr. Inglesby asked if CDC has a role in deciding with WHO when something is considered a public health emergency of international concern (PHEIC)? Dr. Redd responded that CDC staff can participate in the WHO committee who determines PHEICs, but they do not represent CDC in that capacity. CDC does not have a formal role in WHO's PHEIC process.

DSLR Status Report: Operational Readiness Review

Christine Kosmos, R.N., B.S.N., M.S. Director, Division of State and Local Readiness, Office of Public Health Preparedness and Response

Dr. Kosmos provided the BSC with a status report on the Operational Readiness Initiative. DSLR, as well as other divisions across CDC, has worked with state and local partners to improve readiness on the front line for any sort of large scale medical countermeasure event or response. When examining medical countermeasures from the state and local level pre-9/11, particularly in response to an anthrax attack, there was very little capacity or capability to mount any sort of organized, large-scale, medical countermeasure response regardless of location. DSLR has worked over the years with state and local public health to build capacity and capabilities for any sort of large-scale medical countermeasure event.

Pre 9/11, there did not exist structured storage or inventory management systems, plans, trained staff, or incident command systems for large-scale responses. DSLR addressed these challenges through development of State and Local Operational Readiness Strategy. The purpose of the strategy was to assess, evaluate and improve state and local operational readiness for any large-scale medical countermeasure response. The program has now been restructured to include other scenarios outside of anthrax, like emerging infectious diseases. The goal is for the 50 states and four directly-funded cities to be able to demonstrate their operational readiness on or before 2022. Operational readiness is demonstrated and proven through exercises or real events.

During the assessment, some states expressed having capability but no capacity to meet the response requirements of their jurisdictions. DSLR then began strategizing on ways to address these gaps.

As a part of the initiative, jurisdictions have to demonstrate yearly progress and meet work plan deliverables. Ms. Kosmos shared statistics from the most recent evaluation of a two-year cycle covering 2017 through 2019 for five states. This review cycle included 16 data collection forms across three

specific modules. Four of the forms were descriptive, two pertained to planning, and the remaining ten were operational. The chief planning factors contained critical elements needed for an effective MCM response, like points of dispensing (POD) planning; staffing; receive, stage, store (RSS) warehouse logistics; distribution exercising; and security. The purpose of the descriptive forms is to allow jurisdictions to describe the special needs of their locality, which allows for a tailored planning strategy. The operational module requires the jurisdictions to demonstrate capability, whether a functional or full-scale exercise, through series of table tops. This method will allow DSLR to determine if the jurisdiction can fulfill tasks such as facility setup, activating their sites, and notifying and assembling staff. In the 2017-2019 cycle, so far, 23 states have been evaluated as of August.

One of five important pieces of medical countermeasure planning is POD preparation. DSLR has modified a mechanism for jurisdictions to report specific details that need to be in place in order to have an effective POD planning. Plans include identifying their PODs and staff, as well as determining if PODS will be open or closed. In addition, jurisdictions must conduct a thorough drill or exercise to make sure that staff is in place and that they can meet the mission requirements. They must also submit their data to DSLR, which then allows DSLR to ensure detailed plans are in place for each of the POD locations.

An ongoing challenge to state and local public health agencies is having sufficient staff to meet the mission requirements. To address this challenge, localities were asked to delve deeper into the exercise and see if they could answer the following:

Where is the staff going to come from?

Can they open up a POD?

Do they have the ability to mobilize staff to meet the mission requirements?

This gives DSLR the ability to identify where further support to state and local public health will be needed.

DSLR Status Report - continued

Ms. Kosmos also shared some interventions DSLR has identified that will identify solutions for advancing the levels of readiness. In the case of staffing, regional MCM staff worked with jurisdictions to identify solutions, such as a revised POD staffing strategy, amending jurisdictional job descriptions to include responsibility for emergency response, considering mega PODs and POD consolidation, increasing the number of closed PODs, and personnel staffing contracts to support POD staffing.

For example, in Los Angeles, large gaps were identified in the number of PODs they have planned versus the available staff. This required some rethinking to address the gap. Regional MCM staff worked with the county government to find mechanisms that would allow editing of job descriptions to enable the county to activate anyone of the county staff that are not a part of law enforcement, fire, or other mission critical job descriptions.

As another example, Washington, DC has decided that their best available plan is to increase the number of PODs that are closed to the public, whether they are academic centers, hospitals,

universities, or federal closed PODs. Having more closed PODs that are not available to the public takes the pressure off state and local public health. Another jurisdiction decided to contract out for these services and are executing a personnel staffing contract to support their POD staffing.

DSLRL is also looking at some federal staffing solutions, including participating in ASPR's "Last Mile" staffing working group, which is intended to support state, tribal, local, and territorial (STLT) jurisdictions with federal staffing solutions. Another solution is to establish U.S. Public Health Service MCM strike teams.

With regard to logistics and warehousing, states and locals have to be able to receive, repackage, store, and then deploy medical countermeasures. DSLRL requires every jurisdiction to have at least one receipt, stage, store (RSS) primary site/warehouse. This warehouse can receive the materiel from the Division of Strategic National Stockpile (DSNS). There also needs to be one validated back-up site in order to achieve sufficiency in this area.

Jurisdictions also have to demonstrate the ability to distribute medical countermeasures. In order to achieve a satisfactory status in this area, six elements must be in place: chain of custody, cold chain, delivery locations, delivery schedule, transportation method, and transportation routes. DSLRL is working with its SNS partners, who are experts in medical logistics, to understand the mission requirement for state and local public health in terms of distributing countermeasures or supplies from DSNS to either a POD, hospital, etc.

Security has been a major challenge to state and local public health. DSLRL has collaborated with the U.S. Marshal Service to identify mission components that need to be in place in order to assure adequate security for receiving and then distributing countermeasures, which has resulted in much progress in strengthening this area. The components include:

Security lead identified

Evacuation plans in place

Physical security of exterior

Physical security of interior

Security breach plans

With regard to MCM distribution, DSLRL has encouraged jurisdictions to develop partnerships or memorandums of understanding (MOUs) with professional warehousing and logistic companies. It has partnered with SNS to provide detailed technical assistance to state and local public health on medical logistics and determine strategies to ramp up the ability to distribute to more than one warehouse or to hospitals directly thereby reducing the burden on state and local public health.

Lastly, DSLRL and SNS have developed cold chain training for state and local public health. There is a monthly webinar devoted to cold chain management. More resources around cold chain management

are included in OPHPR’s new online technical assistance center and tool that state and locals can access any time day or night. There have also been regional meetings with MCM planners that include discussions on everything from POD planning, cold chain, inventory management, and the SNS request process.

Below is a snapshot of the MCM operational readiness progress made by five of the states.

2017-2019 ORR Status

Jurisdiction	Descriptive	Planning	Operational
Colorado	Established	Intermediate	In Progress**
Chicago	Established	Established	Established
Iowa	Established	Intermediate	In Progress**
Indiana	Established	Intermediate	In Progress**
Kansas	Intermediate	Intermediate	In Progress**

Figure 1. ORR Status Report for Colorado, Chicago, Iowa, Indiana, and Kansas.

DSLRL is revamping this process to construct a tool suitable for territories; it is expected to be released soon. MCM field staff have been deployed to work specifically with the territories on technical assistance and exercise development. If possible, DSLRL would like to extend its MCM field staff to cover all of the HHS regions because it believes that deploying people to the field has made a significant difference in helping jurisdictions.

Next steps for DSLRL includes the following activities:

DSLRL MCM team tracks jurisdictional progress on achieving target goal of operational readiness

MCM ORR site visit report identifies strengths and gaps; technical assistance action plan is developed

Quarterly review of progress on meeting deliverables

Finalize ORR tool for territories

MCM field staff provide technical assistance and support ORRs of local CRI jurisdictions

Expand MCM field staff to cover all HHS regions

Expand the ORR tool to assess planning and operational strengths across all 15 public health preparedness capabilities (Beginning July 2019)

Implement 2019-2024 expanded MCM risk-based planning approach to include pandemic influenza and other emerging infectious diseases

Expand resources and technical assistance via the Online Technical Resource and Assistance Center (On-TRAC)

Recommendations/Comments from the BSC to DSLR:

It's important to say we're never fully ready and that's okay. Operational readiness is an ongoing process with refinements and improvements. Things change, staff changes, and capacity changes. There are all these systems and capabilities in place to support the response, but it will always be an ongoing need to keep the work moving.

Vulnerable Populations and Emergency Preparedness and Response

Amy Wolkin, DrPH, MSPH, Vulnerable Populations Officer, Office of Applied Research, Office of Science and Public Health Practice, Office of Public Health Preparedness and Response

Dr. Wolkin's presentation covered emergency preparedness and response as it relates to vulnerable populations. Vulnerable populations, as defined by Dr. Wolkin, are individuals or groups of people, who may have issues accessing or receiving resources before, during or after a public health emergency. In her presentation, she used the terms vulnerable and at-risk populations interchangeably.

There are many different ways to define a vulnerable population. FEMA uses a functional and access needs approach. This is based on the C-MIST framework, which is an acronym that stands for communication, medical care, independence, supervision, and transportation. This definition addresses a broad set of needs and is irrespective of a specific diagnosis. It is often used by emergency managers because it helps them define the type of services needed. However, it doesn't help with locating those most vulnerable prior to an emergency. Moreover, it's hard to predict what these needs are going to be because there's no adequate dataset that follows the C-MIST framework.

Another way to define who is vulnerable is by population-based subgroups. This may include anyone belonging to a specific subpopulation defined by socio-demographic characteristics or could include persons with disabilities, older adults, pregnant women, children, racial/ethnic minorities, etc. This population-based approach often is utilized by public health and social services because it allows planners to locate and enumerate subgroups of the target population expected to have greater needs. However, just because an individual is identified as being a part of these subgroups, it does not necessarily mean that they will have a need, but based on previous emergencies, they are at higher risk. Some data on these subgroups can be gleaned from resources like the census or the Behavioral Risk Factor Surveillance System (BRFSS).

Previous emergencies have shown that there are certain groups of people that face disproportionate risks during and after a public health emergency. Vulnerable populations face cumulative threats, and preexisting health and economic disparities exacerbate the negative impacts of an emergency. But, there are actions that can be taken to reduce risk and increase resiliency or the ability to recover quickly and fully.

Dr. Wolkin highlighted some of OPHPR's efforts to address vulnerable populations. There are three aims to their work:

Increase CDC's internal capacity to identify vulnerable populations

Increase the external capacity to leverage partnership efforts

Conduct research to improve understanding of vulnerability and to identify effective interventions.

CDC has developed several ways to improve the internal capacity. One way is to increase the visibility, as well as knowledge, skills and capacity through presentations, trainings and publications. Dr. Wolkin leads the Vulnerable Populations Community of Practice, which is comprised of individuals across the agency. The goal is to foster collaboration and garner the expertise of those across the agency who are knowledgeable of various hazards. This also allows individuals to share best practices. The group has quarterly webinars and a newsletter. It has also aided in developing a network of SMEs that can be used a resource.

Also, CDC has formed the At Risk Task Force. Below is an illustration of the types of SMEs available to the task force.

Figure 2. At-Risk Task Force Hurricane 2017 Response



In an effort to respond to the hurricanes of 2017, the task force has developed communication messages for older adults, children, and persons with chronic diseases. It has hosted a clinical outreach and communication activity call (COCA), which discussed the role of primary care providers in supporting children, families, and themselves following a disaster. Mental health is an important area and CDC wants to ensure primary care providers can identify mental health needs and assist CDC in identifying more methods that could assist with the mental health needs of the community. Lastly, the task force created American Sign Language Hurricane Safety Videos in conjunction with FEMA. Six videos can be found on the CDC and FEMA websites and can be used by any news station, for their news broadcast. The videos are general and not specific to the hurricanes of 2017, so they can be reused in the future.

Dr. Wolkin then talked about improving external capacities. CDC collaborates with several agencies and partners and does not always serve as the lead. These relationships are vital during an emergency response. These partnerships are both federal and non-federal. For example, a vulnerable populations' component has been added to DSLR's work. The agency also provides support and technical assistance to external partners as requested.

Vulnerable Populations and Emergency Preparedness and Response - continued

The final component is research. CDC wishes to understand what makes certain individuals and groups vulnerable, explore the relationship between vulnerability and recovery, and identify evidence-based interventions. Below are examples of current research projects:

Effective Communication Tools for Children with Special Health Care Needs

Participatory Mapping to Identify and Support At-Risk Populations in Emergency Preparedness

CoPEWELL- systems dynamic model to assess disaster resilience for the whole community

Counting the Costs- database of disaster related morbidity/mortality by vulnerable population

OPHPR has a broad agency announcement (BAA) for planned research. No FY 18 awards have been disbursed yet but there are several activities that the Office anticipates undertaking that address the needs of vulnerable populations. One seeks to identify evidence-based interventions to mitigate adverse impacts on at-risk populations. This will garner the best evidence-based interventions available for specific subpopulations. The second is identifying information needs and optimal communication channels for reaching at-risk populations during emergencies. This will address information needs and seeking behaviors, identify best practices, optimize communication, and disseminate knowledge to public health practitioners. Third is the dissemination of critical research findings to a broad public health audience. This will make research findings more accessible to practitioners who may not have access to certain journals, and it presents it in a format that could be easily understood. Last is the development of training modules for rapid response research. For this project, modules for vulnerable populations and mental health will be developed. These modules will be online and freely accessible. A series of resources will also be made available.

Dr. Wolkin ended her presentation with several questions and asked the BSC's to help answer the following:

What questions about vulnerable populations and emergency preparedness and response should CDC address with future research or program evaluation efforts?

What are *additional* ways to identify evidence-based practices? How can we identify success stories from practitioners that are generalizable and replicable?

How can CDC incorporate the influence of social vulnerabilities (e.g., poverty) into response efforts when staff expertise is focused on specific subpopulations?

Recommendations/Comments from the BSC:

Areas where a lot of work remains to be done is both basic science as well as applied. Poverty poses a particular challenge in terms of two things: accessing the right information and processing that information (hard-to-reach versus hardly reached populations). Part of the challenge in processing, understanding/comprehending, and acting on that information stems from the limited bandwidth to focus on a variety of issues that happen daily to this population. Addressing this issue requires basic science work to understand what happens under those conditions in accessing and processing information but also some work in terms of translating it.

Another comment was that research projects need to ensure that they include sufficient numbers of poor people to be representative. National surveys or projects that do not include a sufficient number of poor people are no longer acceptable because it will not allow for the drawing of appropriate inferences.

Field responders, like the ASL sign language interpreter for example, have been to many of sites post-disaster and have been working with individuals with a variety of vulnerabilities. They might be able to at least begin to identify some areas of concern. As more engagements occur with other organization partners, some common ideas will begin to develop that are at least promising practices, which could lead to research about what is really effective or create the mechanism by which to test ideas.

Begin to pull together groups that can create linkages between resiliency and addressing social determinants of health.

It would be interesting to see if there were ways to track the impact of social determinants on populations in a disaster. Tap into some of the efforts that people are working on whether it'd be housing, transportation, poverty, etc. You can begin to structure the social determinants of health into resiliency-building and emergency preparedness work. For some entities or leaders, it may increase their understanding by framing it that way.

Over time, determine if it will be worth disaggregating the term vulnerable populations a little more specifically in order to gain more resources and ascertain the specific needs for this group (or at least disaggregate during each specific response/recovery period). When talking about at-risk or vulnerable populations, it's such a large designation that it may not allow very concrete specific interventions in a

way that's seen in other parts of public health preparedness practice. The more specific you can be, may result in more effective interventions or programs.

BSC Member Discussion

BSC Members were afforded this time to revisit any of the subjects covered in the webinar or raise new questions. OPHPR leadership also asked the BSC to cover a few areas of interest to the office. The first is topics for future meetings. Some topics have been proposed for the October 2018 meeting, including the following:

Private sector and public health collaborations in preparedness and response.

Update on CDC's recent refresh of the Surveillance Strategy.

Update on the data preparedness

Update on the recent pan flu exercise and other activities occurring at CDC

Dr. Groseclose also proposed a solo or panel discussion, where members could share information from their areas of expertise and determine ways to engage with CDC on their projects.

Future BSC meeting topic ideas from the BSC Members included the following:

Select Agent Program: status of inactivation and information from the Laboratory Response Network regarding their process to assay development and how they're handling some of the new technology, code genome sequencing as well as other assay development and validation.

Biggest problems the states are now facing that they'd like CDC to understand. This can be a dialogues between states and CDC to the board.

Results of the September pan flu exercise

The World Economic Forum also has a very substantial effort underway to engage global companies in pandemic preparedness and response and is doing a number of things in communications, logistics and supply chain, data management. It has a number of Fortune 500 companies engaged in that work. It might be interesting for OPHPR, if it's not already involved in that work, to get a briefing from them.

Update about how EOC expertise are being used for the Global Health Security Agenda work that's going on at CDC.

Update on the National Health Security Preparedness Index: where we are going and how we are thinking about the future.

The extent to which OPHPR is running the national plans for particular kinds of emergencies. For example, a smallpox emergency or anthrax. For those big plans for specific scenarios, is that something that OPHPR manages? If so, it'd be useful for the board to hear about it at a higher level.

Dr. Inglesby requested the CDC program responses to BSC meeting recommendations be received in writing, if it does not cause a burden to the OPHPR staff. This will allow the board to engage in a discussion. Dr. Groseclose suggested the use of an action item or follow-up list that could be compiled and shared at the close of the meeting. Dr. Slemph suggested any areas, in those action items, that require a deeper dive to gain complete understanding be considered for the next meeting's agenda.

Public Comment Period

No public comments.

Meeting Recap/Meeting Adjourn

Before closing the meeting, Dr. Redd thanked the BSC Members and Liaison and Ex Officio Members for their participation. The discussions provided useful feedback for OPHPR to follow up on. He looks forward to more rich discussion in the upcoming in-person meetings. Drs. Groseclose and Lochner added their appreciation for the BSC's valued input. Dr. Inglesby, before adjourning the meeting, thanked OPHPR leadership and staff for planning and orchestrating the web conference and thanked all that participated for being a part of the call.

CERTIFICATION

I hereby certify that to the best of my knowledge, the foregoing minutes of the August 30, 2018 meeting of the OPHPR BSC are accurate and complete.

_____/s/_____
Date Thomas V. Inglesby, MD
Chair, Board of Scientific Counselors, OPHPR

APPENDIX A: OPHPR BSC MEMBERSHIP ROSTER

DESIGNATED FEDERAL OFFICIAL

Kimberly Lochner, ScD
Deputy Associate Director for Science, OPHPR
Centers for Disease Control and Prevention
Atlanta, GA
Kdl4@cdc.gov

CHAIR

Thomas Inglesby, MD, Chair
Director, Johns Hopkins Center for Health Security
Johns Hopkins Bloomberg School of Public Health
Baltimore, MD
tinglesby@upmc.edu

MEMBERS

Margaret L. Brandeau, PhD
Coleman F. Fung Professor, School of Engineering
Department of Management, Science and Engineering
Stanford University
Stanford, California
brandeau@stanford.edu

Sandro Galea, MD, MPH, DrPH
Dean, School of Public Health
Boston University
Boston, Massachusetts
sgalea@bu.edu

Erika James, PhD, MA
John H. Harland Dean
Goizueta Business School, Emory University
Atlanta, Georgia
erika.james@emory.edu

Brent Pawlecki, MD
Chief Health Officer
The Goodyear Tire & Rubber Company
Akron, Ohio
brent_pawlecki@goodyear.com

Alonzo L. Plough, PhD, MPH
Vice President for Research and Evaluation and Chief Science Officer
Robert Wood Johnson Foundation
Princeton, New Jersey
aplough@rwjf.org

Catherine C. Slemph, MD, MPH
Consultant, Public Health Policy and Practice
Milton, West Virginia
cathy.slemph@att.net

Kasisomayajula Viswanath, PhD, MA, MCJ
Lee Kum Kee Professor, Health Communication
Department of Social and Behavioral Sciences
Harvard School of Public Health
Boston, Massachusetts
Vish_viswanath@dfci.harvard.edu

EX OFFICIO MEMBERS

Department of Defense

Jody R. Wireman, PhD, MSPH, MPA
CIH, DABT HQ NORAD-USNORTHCOM
Director, SG Force Health Protection
Peterson AFB, CO
jody.r.wireman.civ@mail.mil

Alternate - Eric Deussing, MD, MPH
Commander, Medical Corps, US Navy
DoD Liaison to CDC
Atlanta, GA
ncu0@cdc.gov

Department of Health & Human Services

Sally Phillips, RN, PhD
Deputy Assistant Secretary for Policy, Office of the ASPR
US Department of Health and Human Services
Washington, DC
sally.phillips@hhs.gov

Department of Homeland Security

Anthony Macintyre, MD
Senior Medical Advisor, FEMA
Countering Weapons of Mass Destruction (CWMD)

Department of Homeland Security (DHS)
Washington, DC

LIAISON REPRESENTATIVES

Christina Egan, PhD, CBSP
Association of Public Health Laboratories (APHL)
Chief, Biodefense Laboratory, Wadsworth Center
New York State Department of Health
Albany, NY
christina.egan@health.ny.gov

Laura Magana, PhD
Association of Schools and Programs of Public Health (ASPPH)
President and CEO
1900 M St NW Ste 710
Washington, DC 20036
lmagana@aspvh.org

Marissa Levine, MD, MPH
Association of State and Territorial Health Officials (ASTHO)
Chief Deputy Commissioner
Virginia Department of Health
Richmond, VA
marissa.levine@vdh.virginia.gov

Patricia Quinlisk, MD, MPH
Council of State and Territorial Epidemiologists (CSTE)
Medical Director and State Epidemiologist
Iowa Department of Public Health
Des Moines, IA
patricia.quinlisk@idph.iowa.gov

Michele Askenazi, MPH, CHES
National Association of County and City Health Officials (NACCHO)
Director, Emergency Preparedness and Response, Tri-County Health Department
Greenwood Village, CO
maskenazi@tchd.org

Jamie Ritchey MPH, PhD
Director, Tribal Epidemiology Center (TEC)
Inter-Tribal Council of Arizona (ITCA)
Phoenix, AZ
Jamie.Ritchey@itcaonline.com

APPENDIX B: BSC Meeting Attendance Roster, Atlanta, GA – August 30, 2018

BSC Web Conference Attendance Roster
Atlanta, GA – August 30, 2018

NAME	AFFILIATION	
Inglesby, Thomas	Chair and SGE	Present by phone
Brandeau, Margaret	SGE	Absent
Galea, Sandro	SGE	Present by phone
James, Erika	SGE	Absent
Pawlecki, Brent	SGE	Present by phone
Plough, Alonzo	SGE	Present by phone
Slemp, Catherine	SGE	Present by phone
Viswanath, Kasisomayajula (Vish)	SGE	Present by phone
Phillips, Sally	Ex Officio	Present by phone
Wireman, Jody	Ex Officio	Present by phone
Dreyzehner, John	Liaison	Present by phone
Askenazi, Michele (NACCHO)	Liaison	Present by phone
Shah, Dhara	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)