

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

OFFICE OF PUBLIC HEALTH PREPAREDNESS AND RESPONSE (OPHPR)

BOARD OF SCIENTIFIC COUNSELORS (BSC) MEETING

SUMMARY REPORT / RECORD OF THE PROCEEDINGS

AUGUST 5, 2013

WEB CONFERENCE

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**CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
OFFICE OF PUBLIC HEALTH PREPAREDNESS & RESPONSE (OPHPR)
BOARD OF SCIENTIFIC COUNSELORS (BSC) WEB CONFERENCE**

**1600 Clifton Road, NE
Atlanta, GA
August 5, 2013**

WELCOME

Thomas Inglesby, MD, Chair, OPHPR BSC, welcomed all participants to the BSC meeting.

ROLL CALL AND REVIEW OF FACA CONFLICT OF INTEREST

Samuel L. Groseclose, DVM, MPH, Associate Director for Science, OPHPR and the Designated Federal Official (DFO) for the OPHPR BSC called the BSC meeting to order and took roll. BSC Special Government Employee (SGE) Board Members, ex officio Board Members, and liaison Board Members are listed in Appendix A. Those participating on the call are listed in Appendix B. Quorum was met.

Dr. Groseclose thanked participating board members for submitting their financial disclosure records, which made them eligible to participate on the call. He then reviewed the duties of the Board per the BSC charter. Dr. Groseclose asked for members to self-identify any conflicts of interest. Dr. Groseclose asked that if a BSC Member believed that they did have a conflict of interest, s/he should draw that to his attention.

The Board welcomed Dr. Marissa Levine, the new liaison representative from the Association of State and Territorial Health Officials.

OPHPR INTERVAL UPDATE

Daniel M. Sosin, MD, MPH, (Deputy Director, OPHPR) updated the Board on some key activities that have occurred since the last in-person BSC Meeting (April 2013)

- Division of Select Agents and Toxins (DSAT)
 - Implementation of *Select Agent Regulations* and *Import Permit Regulations*
 - Select Agent Regulations
 - Developed as a result of an Executive Order to tier select agents
 - 54 inspections of Tier 1 possessing entities since April 2013
 - Community has done well in meeting new security requirements
 - Community will need additional assistance in meeting incident requirements and in developing procedures for IT security
 - Import Permit Regulations
 - Site-specific biosafety plans are a new requirement
 - National webinar co-sponsored with CDC's Division of Global Migration and Quarantine and with the Department of Homeland Security to provide education and information about the new regulations
 - Inspection program for importers of high-risk biological agents –newly initiated by DSAT
- Division of State and Local Readiness (DSLRL)
 - Field operations
 - Hired and placed 9 entry-level CDC employees in state and local public health departments
 - Are transitioning the Career Epidemiology Field Officer program to DSLRL from the Office of Science and Public Health Practice
 - Grant alignment activities with the Assistant Secretary for Preparedness and Response (ASPR)
 - 70% of awardees report significant reduction in burden due to alignment efforts
 - Future work will include Federal Emergency Management Agency (FEMA) in alignment efforts to: incorporate common language; develop guidance documents; make linkages between Health and Human Services (HHS) preparedness capabilities with the national core capabilities; coordinate CDC's risk-based pilot project with the Threat Hazard Identification and Risk Assessment Process
- Division of Strategic National Stockpile (DSNS)
 - July 2013: Howard County, Nebraska, healthcare preparedness workshop and meetings
 - Part of an outreach effort to integrate healthcare and public health in rural settings
 - Healthcare Preparedness Activity (HPA) has conducted similar activities in large metropolitan areas
 - Nebraska project: the first for rural areas
 - Annual Review
 - The 2012 SNS Annual Review Report addressing corrective actions for FY 15 was completed in Spring 2013
 - The 2013 SNS Annual Review is underway, and will address priorities for FY16 SNS spending.

- Division has completed several trainings and exercises related to response and dispensing: 47 objective-based external training events (972 participants); 28 realistic external exercises (10 full-scale, 3 site-security exercises with US Marshals)
- Anthrax-related activities
 - DSNS now focusing on “the next 50 days” as a continuation to its planning for the first 48 hours after an anthrax incident
- Division of Emergency Operations (DEO)
 - Emergency Management Accreditation Program
 - Suggested activity from the 2010 BSC Review
 - Process will last 18 months and has 64 standards
 - DEO well underway to meeting requirement
 - CDC Director’s priority for global health security
 - DEO role: bring together Emergency Operation Center (EOC) components with epidemiology and laboratories to ensure countries have the resources and standard operating procedures needed to conduct emergency response activities
 - DEO has been involved in global health security efforts in China, Uganda, Vietnam, Kenya, Korea
 - Emergency Management federal job series has been developed by PHPR
 - Recommended activity from the BSC
 - Current EOC activations
 - Polio (ongoing since December 2011)
 - H7N9 (from April 1, 2013 until June 14, 2013)
 - Middle East Respiratory Syndrome Coronavirus (MERS-CoV) (ongoing since June 3, 2013)
- Learning Office (LO)
 - Responder Training Needs Assessment
 - Includes follow-up with responders on the 6 most recent EOC activations
 - Report has been written that is being used to define future training needs
 - Personal Preparedness Pilot Project
 - A collaboration with the Office of Safety, Security, and Asset Management (OSSAM)
 - Plan is to engage the entire CDC workforce in developing relevant preparedness behaviors and ensuring effective workforce training through CDC’s Office of Safety, Health, and Environment’s Lifestyle Program
- Communications Office (CO)
 - Preparedness Month (September) activities are being organized in collaboration with several other offices
- Office of Policy, Planning, and Evaluation (OPPE)
 - OPPE is heavily involved in preparing the National Health Security Preparedness Index (NHSPI) for final release
 - NHSPI team will be addressing comments from the recently-completed beta testing
 - Anticipated launch date: October 2013
 - Collaborations with partners
 - OPPE has developed a partnerships web portal

- Public health security e-newsletter being shared with 7000 subscribers (including the BSC)
- Office of Science and Public Health Practice (OSPHP)
 - Hurricane Sandy research grant program
 - \$8 Million given to CDC to fund Hurricane Sandy research
 - Funding has been aligned with a request for proposals, submission of proposals and a review process
 - Funding process is in the late stages of review and projects will require collaboration with health departments
 - Topic areas to include: assessment of mold-related health effects and mold-mitigation efforts; characterization of morbidity and mortality and associated risk factors; evaluation of the effectiveness of the response of the public health system; assessment of exposures and health hazards to response workers and volunteers
 - ASPR will be coordinating with CDC on Hurricane Sandy research grants
 - ASPR also received \$8 Million for research
 - CDC and ASPR will support a collaborative secondary review process of grant proposals
- Financial Resources Office (FRO)
 - Currently involved in the 2014 fiscal allocation process
 - Discretionary funds are expected to be limited this year
 - FRO now working through the requirements of a new platform that will monitor and manage projects
- Full-scale anthrax laboratory response exercise (beginning today)
 - Laboratories across CDC involved to receive samples and engage in activities that test CDC's processes
 - Goal is to ensure CDC labs are able to handle the surge in lab testing resulting from a wide-area anthrax release
- Small Business Innovation Research (SBIR)
 - All federal agencies required to put a fraction of funds into SBIR
 - OPHPR has been identifying topics of broad interest to CDC in an effort to engage other parts of the Agency
 - Applications currently being received for projects related to sample collection, preservation, and transport
 - Anticipated topic for next year: improving rapid antimicrobial susceptibility testing
- Elaine Vaughan, BSC Member (in memoriam)
 - Recently lost her battle with cancer
 - Had been an active participant on BSC calls and routinely provided suggestions and input
 - Research professor and professor emerita in the Department of Psychology and Social Behavior at the University of California, Irvine
 - OPHPR acknowledges Dr. Vaughan's contributions to the BSC and to improving our nation's health security.
 - OPHPR leadership would like to express our sincere condolences to Dr. Vaughan's family.

QUESTIONS & DISCUSSION (OPHPR INTERVAL UPDATE)

SGE: With regards to DSAT, you mentioned the community will need additional assistance in developing occupational health programs, meeting incident requirements, and developing procedures for IT security. Can you expand on that?

CDC: There have been 50 site visits conducted thus far, which account for one-third of the sites. The remaining two-thirds will have site visits within the next year. To address gaps identified, several activities will occur.

The first is to have a meeting with the Department of Agriculture to compare our findings to theirs. Monthly steering committee meetings are being conducted and initiatives will be developed to address the gaps identified. Guidance documents for occupational health have been developed for tier-one select agent security and IT security. They will be reviewed to identify areas that should be strengthened, and it is possible that additional subject matter experts will be utilized.

There are some supplementary communication tools in the toolbox. Annual select agent webinars are also being offered. The next one is scheduled for November. There will be more information regarding the gaps provided at the November webinar.

SGE: Does occupational health include biosafety issues?

CDC: Biosafety is regulated by DSAT in terms of containment of organisms and agents in the laboratories. DSAT also has expanded the regulations to look at occupational health from two perspectives. One perspective is to enable entities to optimize their incident response plans to ensure good understanding of occupational health issues associated with the select agents and toxins. DSAT also ensures that the agents and toxins they use in their work are incorporated in their response plans. Furthermore, DSAT will assist entities that want to include an occupational health component in its programs.

SGE: Are there any challenges in terms of getting in specimens in the midst of outbreaks, like H7N9 or MERS-CoV, or is that being navigated efficiently?

CDC: It has been navigated efficiently over the last year. Lessons have been learned from the 2009 H1N1 outbreak. We work more closely with our colleagues in agriculture, in terms of coordinating permits, and also with colleagues at DHS Customs and Border Protection. We are being proactive to ensure that we're ahead of events. With the new surveillance systems, which are much more sensitive, we can respond quicker and work with the Customs and Border Protection colleagues to make sure paperwork and permits are in order. Thus far, there have been no issues with respect to MERS-CoV response or H7N9.

One of the tricky aspects of MERS-CoV response is that one of the countries is recognized as a foot and mouth disease positive country. As a result, more coordination has had to occur to ensure samples are screened in Plum Island Animal Disease Center before being dispersed to laboratories.

CDC: It has been a lot of work to navigate, but a large commitment has been made to ensure that the right tools are provided to ensure protection and to make certain that emergency response is not encumbered.

ASSESSING THE COST OF PREPAREDNESS

Lynn Austin, PhD, Deputy Director, OPHPR, provided both a background and an update to the BSC on this project. The original proposal was to develop – for publication – an estimated cost of preparedness, to include the following elements:

- CDC core preparedness response capabilities
- State and local public health emergency preparedness (PHEP) capabilities
- DSNS cost for countermeasures

Challenges

- Federal budget has been a bit of a moving target
- Concerns about how funding would be presented

Increased preparedness and response funding started in response to 9/11 and has decreased thereafter

Cost of Preparedness Project intent

- Capture gaps in preparedness
- Illustrate increasing vulnerabilities in
 - CDC preparedness and response capabilities
 - State and local capabilities and public health infrastructure

Funding cuts at state and local levels

- Impacts core functions and surge capacity for response
- Since 2001
 - Funding for state and local PHEP cooperative agreements have been reduced 42%
 - Decrease of 45,000 state and local preparedness or public health infrastructure jobs
- Federal, state, and local governments will likely continue to have vulnerabilities due to further reductions, furloughs, layoffs, and staff turnover

Estimating the cost of preparedness

- CDC core capabilities, as well as innovative short-term projects, were compared to the required components identified in the National Strategic Plan for Public Health Preparedness and Response
- Core funding has been reduced over the last couple of years, so there is a gap
- DSLR staff estimates an additional \$11.9 billion is needed to fully achieve PHEP capabilities

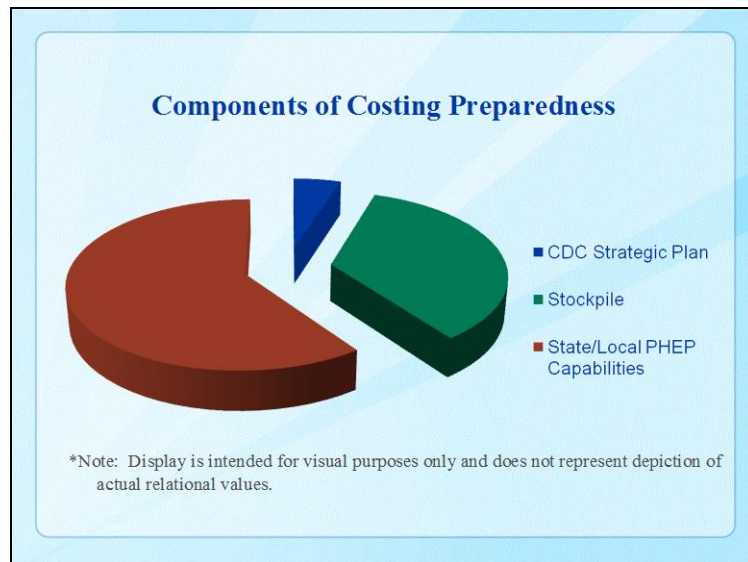
SNS costs

- Medical countermeasures (MCM) broken out as a separate funding requirement for late consideration
- Varies depending on full implementation of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) requirements and/or maintaining the existing inventory of MCM
- Cost varies each fiscal year due to inventory shelf life and replacement costs. For example, \$949.83 million will be needed in FY-2019 compared to \$979.26 million in FY-2021.

Core preparedness components include: laboratory, surveillance, epidemiology, medical surge, planning, exercises, EOC, and emergency communications

Estimating cost

- Includes making the assumption that every nuance of the public health infrastructure could not be measured
- Overarching costs divided as in the pie chart below



Identifying gaps

- Existing funded projects have been aligned with the strategic plan
- Gaps identified where initiatives not currently funded
- Cost of innovative projects and activities to address gaps has been estimated
- Remaining gap analysis activity: determine the cost of core preparedness response activities, funded and unfunded
- Matrix will be created for identified gap projects over the next 4-6 weeks (anticipated)

Final thoughts / Summary

- Accomplishments made up to now vary by grantee and their capabilities
- Gaps exist between what has been funded and accomplished and what is needed
- DSLR spent time examining what it would take to measure the PHEP capabilities
- An economic formulary is being proposed
- Dr. Austin suggested a journal publication as the best method to present the data, but asked the Board for their thoughts
- Proposed Cost of Preparedness model will exclude
 - Core public health functions except those specifically included as part of the PHEP capabilities
 - Community resilience and recovery as a sustained recovery approach.

QUESTIONS & DISCUSSION (ASSESSING THE COST OF PREPAREDNESS)

SGE: Can you elaborate on the \$11.9 billion. Is it annual or one-time? If we complete this task, will we be prepared?

CDC: It is not an annual cost. The amount is what it would cost to make us fully-prepared, but it does not take into account operational maintenance to continue the capability going forward.

SGE: Do you plan to add that to the analysis?

CDC: I would have to go back to DSLR (the Division of State and Local Readiness in OPHPR) to see if that is possible. There will probably be some assumptions around the public health infrastructure environment, but it might be possible.

CDC: We would want to answer this going forward, but we have not had that deliberate discussion on how to do that yet.

SGE: Projects seems like a small word versus what we're really doing, which is systems. So, do you mean something more enduring, when you say "projects"?

CDC: We use the term project both ways. We also call our CORE activities "projects" and they can be long-standing or may not have a finite end date. But, we do try to distinguish CORE from what we call sun-setting projects.

CDC: This grossly underestimates the complete system cost for all the threats because no individual program has had the opportunity to think completely through every threat.

CDC: Regarding the PHEP state and local capabilities around building to the capacity, we looked at their scores against the capabilities and what it would take to achieve 100%. It does not include ongoing operational costs. We call it a Capabilities Planning Guide (CPG) score. We can send you that report once we've completed it. It is right now in draft form.

SGE: So, in the next month or two, we will get to review the document?

CDC: Yes.

SGE: Those details will help us have a more rich discussion and we can provide better guidance on how to present the data.

SGE: This seems a little CDC-centric. Could methodology be extended to look at the breadth of preparedness with the National Health Securities Preparedness Index (NHSPI)?

QUESTIONS & DISCUSSION (ASSESSING THE COST OF PREPAREDNESS, CONTINUED)

- CDC: That is a good suggestion and that may be a Phase II project for the Index Team.
- SGE: It would be useful to see how much of this will have an impact immediately in the public health infrastructure versus things like the stockpile that will be used only in the case of an emergency.
- SGE: Is the stockpile separated from the \$11.9 billion?
- CDC: Yes, that number is separate. The numbers depend on the amount of products that have to be replaced and therefore vary each year. Since it's about purchasing product, maintaining, planning, and research on the use of products, should it be included in this report when we're talking about the capabilities for state, locals, and CDC, or should it be separate?
- SGE: For the vast majority of systems that I've been involved in, I've never seen a single measure of preparedness. I don't know if you can separate this out. There is always more than one measure for preparedness. This is where capabilities, understanding the communication, and some of the other items discussed at the last meeting need to be considered.
- CDC: I agree. These are the three areas that CDC works most closely with. What you are speaking on is more of what the (NHSPI) will do, which is a much broader framework. This is not meant to be everything it takes for the U.S. to be prepared, but is what is within our parameter to monitor.
- SGE: In the systems I've been involved with, there have been multiple definitions of preparedness. I've never seen a single indicator or measure for things occurring in a complex system. I can't put faith in any single measure. You risk leaving out so many things. I would suggest multiple indicators.
- CDC: There are 15 defined capabilities, and there are performance measures; albeit, insufficient and only addressing a part of the scope of capabilities, at present. They define the work of public health and emergency response. By looking at those, we can estimate the cost to achieve full preparedness under those existing performance measures. It's a work in progress, but it's broken down into multiple components.
- SGE: Maybe somebody can come up with three or five that would affect the mix or the combination assuming the measures are interdependent.

QUESTIONS & DISCUSSION (ASSESSING THE COST OF PREPAREDNESS, CONTINUED)

SGE: What might be helpful when you disseminate the draft is to consider how it's titled. The title *Estimating the Cost of Public Health Preparedness* is broad. What it is really doing is estimating the *cost of state and local preparedness and CDC's support of those efforts*. This may help lead to the next analysis of what it would take to get everyone at the best possible levels of the NHSPI, which is a broader circle beyond state and local readiness.

In terms of style, for Washington, it is better to describe what happens if you do not have these capacities. In today's world people react more to what they're not getting, what they're worried about, and their concerns. That might make the argument more compelling.

CDC: Can you and others share some analysis of how that might be done for emergency response?

Liaison: It's my understanding that HHS is calculating a return on investment (ROI) in preparedness. Will that be a complementary activity?

CDC: I am not familiar with that project. I thought their ROI project was more about what we've paid for so far versus addressing gaps. They've not linked with us directly on that.

Liaison: I will forward what I have right now, but they are looking at methodologies to cost out capabilities for PHEP and Hospital Preparedness Program (HPP).

CDC: At one time, they had been linking with DSLR's Evaluation Branch, but I'm not sure about recently.

SGE: Back to linking the stockpile to this effort, if you title it clearly you could include both or do them separately or as a companion analyses. You could call it the cost of public health preparedness.

As far as economic and political sensitivity, be prepared for pushback on the elements. The better you can define those elements, the better it will be. A group with economic chops and respected for economic analyses, outside of CDC, would be useful to employ in that area.

CDC: We walk a fine line between the administration and our budget. It gets to a point where it's difficult for us to publish but if we're working with other groups, it's considered open-access information, which could be used in other ways that are normally restricted for CDC.

QUESTIONS & DISCUSSION (ASSESSING THE COST OF PREPAREDNESS, CONTINUED)

SGE: I understand people would like a single number and a nice closed system. But I see the need for system “separate-ability.” What can be separated, if only for the analysis? I would like to see an analysis on what is included versus not included and what things if left out will impede or hurt us.

SGE: We can look at this further in the fall meeting.

Liaison: Building on the last comment, there are several other resources utilized at the state and local levels than just federal. Are these numbers just the federal dollars? There are many other costs that didn’t get counted.

CDC: That is a good question. Our DSLR colleagues tell us that the estimates considered the federal funds that have gone into this so far to bring us up to that level, so the gap would be federal only.

CDC: We would like to hear from board members on the importance of being able to convey what the gaps means in terms of lack of capability. A few months ago NACCHO sponsored a workshop on preparedness in light of an improvised nuclear device (IND) detonation that graphically laid out the enormity of responding to such an event and our readiness to respond. How would we convey to Congress either in specific scenarios or generically what the lack of capabilities would mean to lives, economic costs, etc.?

SGE: We do have a history of past disasters and the lives lost. It could be related in some way to the lack of preparedness. Use those disasters to ground the scale and make it understandable.

SGE: Using the IND, you can say at the current funding, a state could care for 50 burn patients but needs to have enough to treat 200 people, and we need to move burn patients to other part of the country. The delta between the two is X and our estimate of the cost of building X is this. This will help them understand and that you’re identifying a gap in care for burn patients. Since, this will be a public document, it should be explained in clear language what we need to build, why, and what happens if it doesn’t happen.

Liaison: I think one thing that doesn’t get factored in is emergency action or reaction. What if people don’t get the information and they do the wrong thing, which caused them more harm? A measure of impact in that aspect should be developed.

Dr. Inglesby concluded by asking the board members to continue to provide further ideas around this subject to Dr. Austin.

MEASURING OPERATIONAL READINESS – AN UPDATE

Jeff Bryant, MS, MA, Chief of the Program Services Branch, Division of State and Local Readiness (DSLRL), OPHPR, and **CAPT Thomas Bowman, MS**, Program Services Branch, DSLRL, presented an update on work first presented to the BSC at the in-person board meeting held in April 2013.

April 2013: problem statement presented to the Board for further thoughts

- Problem: how to more accurately ascertain the nation's ability to plan for and use medical countermeasures (MCMs) delivered from the Division of Strategic National Stockpile
- DSLR needs an assessment and review process that better measures the ability of the nation to execute the MCM plan

Thomas Bowman has held several meetings with awardees and subject matter experts and will now update the BSC

June 4 – 5, 2013: DSLR held a two-day workshop

- Participants included representatives from ASTHO, NACCHO, state awardees, and directly funded localities
- participants conducted a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of the Technical Assistance Review (TAR) and CDC's public health preparedness capabilities
- Identified weaknesses of TAR included
 - It's not an operational or evaluation tool
 - We have outgrown the process
 - It's not "all-hazards"
 - It provides a false sense of security and preparedness by just evaluating plans
- Strengths and opportunities identified
 - Develop a maturation model using tiers and scales
 - Define what is meant by "operational readiness"
 - Define operational readiness as capacity and competency
- Recommendations included
 - Peer group technical assistance and review
 - Establishing minimum standards and performance measures
 - Linking the PHEP and HPP capabilities
- Most significant threat identified: resistance to change from established norms
- Additional discussion topics
 - Evaluation methodology
 - Demonstration of capabilities
 - Supporting capabilities
 - Review of existing models like
 - NHSPI
 - NACCHO Project Public Health Ready
 - Radiological Emergency Preparedness Program
 - National EMS Model

July 30-31, 2013: DSLR held another two-day workshop

- Expanded representation from ASTHO and NACCHO, state awardees, directly funded localities, and local health departments
- Participants asked DSLR for information about the following
 - Ways to break down operational readiness by incident phases
 - Operational indicators
 - Gap analysis in terms of concept of operations, communications, epidemiology
- Discussions focused on how to define operational awareness
- Participants were tasked with several questions
 - What are the components of operational readiness?
 - What is relationship between medical countermeasure planning and other public health preparedness capabilities?
 - How do we measure operational readiness? What metrics do we use?
 - How do we demonstrate operational readiness? Exercises? Other methods?
- Workshop suggestions
 - Develop a tiered response
 - Look at what health departments do daily that is the same as what will happen during a medical countermeasure event, and use that for evaluation (e.g., flu clinic activities)
 - Don't allow the scenario to drive the exercise, but instead, let the improvement plan drive the scenario and then build the exercise around that
- Hot topic: real world events
 - How can the lessons learned from Hurricane Sandy be used to demonstrate capability
 - How can the after-action plan improvement process be used to identify areas in need of remediation?

December 2013: Design and package the new assessment tool

- DSLR will continue to engage partners – three virtual work groups established
- At present, many great ideas proposed, but no good course of action
- Each workgroup will be tasked with making a concept plan for the new assessment tool
- Assessment tool will be incorporated into the new guidance in HPP-PHEP Budget Period 3 continuation guidance

QUESTIONS & DISCUSSION (MEASURING OPERATIONAL READINESS)

- SGE: Do you think the outlines of the options are already visible given your discussions in the workshop?
- CDC: There are some definite trends but we're not at specifics yet.
- SGE: Do you have an idea of the most valuable way to proceed?
- CDC: I think we have some ideas. There was an interest by the group to look at this by categories or public health capabilities instead of an end-score. You can do an evaluation on those pieces rather than a whole, which reveal gaps. Some pieces were identified as showstoppers and therefore essential.
- SGE: In other systems, they have identified outstanding performers. They've done intense analysis of the whole management operation. The best organizations have incorporated crisis management into daily operations, and it affects the betterment of their day-to-day procedures. You may need to identify a group who has done this well and doesn't stop once they get a score—but it's a part of their regular process. Determine what is in their culture that supports that effort. An organizational anthropologist may be useful in that regard.
- SGE: For the other PHEP capabilities, do they receive anything like a TAR score other than countermeasure distribution?
- CDC: Capabilities 8 and 9 relate to warehouse and distribution and are the only capabilities with that type of assessment. The drill was to understand volunteer management, information sharing, emergency public information, warning, etc.—without which you won't have a successful distribution and dispensing mission. The goal is to incorporate some of those other capabilities.
- CDC: It then helps to identify the gaps. DSLR staff used the best formulary they could for the grantees, but it's not hard science. Better tools to get to a better measurement would help us all.
- SGE: I feel like one of the reasons for the TAR was due to the lack of confidence in whether state and locals could do this. Do we need something as specific as the TAR score? Do you have a plan for looking at each PHEP capability with this level of detail or is this an area of challenge?
- CDC: Few of the other capabilities have the onerous mission of dispensing countermeasures in a very short window of time for an isolated event. That drove some acute interest in developing a measure. I can't think of a corollary that would cause that type of a mission requirement, so that's part of it. I don't think we're married to an individual score, but more so that state and locals are on target, understand the mission, and can meet the mission requirement.

CDC: Many parts of the program are constantly looking at all the performance measures and identifying ways to improve targets and measures.

SGE: In October, will you have it down to one option?

CDC: We certainly hope so, and we will report back to you if that's your desire. Part of what brought us here was the balance of benefit versus awardee burden. We're trying to get away from that.

PUBLIC COMMENT PERIOD

The floor was opened for public comments.

- SGE: The interface of measurements for readiness and modeling of readiness are important ideas. It's important to see how components work together as a system. I would hope that Tom Bowman and colleagues are looking for metrics that can fit with downstream computational modeling information.
- CDC: It's probably been in the back of our minds but it is important in determining ways to reduce burden.
- SGE: There's a large group, MIDAS (Modeling of Infectious Disease Agent Study), funded by NIH that does epidemic modeling of infectious disease. The MIDAS group or similar modeling entities have skill sets that need to be brought to bear on this problem.
- Public: I heard Dr. Lynn Austin talk about estimating costs and I'm coming from a congressional staff viewpoint. We're assuming that everything we're currently doing is being done as efficiently as possible. Another part of the discussion needs to come from the preparedness enterprise regarding potential cost savings and strategies for lower costs. If you look operationally at how we conduct preparedness and response activities, you'll find that duplication occurs at all levels in all preparedness and response programs. So this area deserves more attention and we need to do an assessment of where we can find savings.

CLOSING THOUGHTS

Dr. Sosin

- Recognized Dr. Don Burke (OPHPR BSC SGE) whose term of service on the BSC is ending
- Acknowledged Dr. Lynn Austin, who will be leaving CDC in October to join the U.S. Securities and Exchange Commission as a Senior Manager in Boston

Dr. Groseclose

- Seconded Dr. Sosin's sentiments
- Thanked the Members, Ex Officio Members and Liaison Representatives for their participation
- There will continue to be webinars in an effort to keep the Board informed
- BSC will meet again, in-person, October 16-17, 2013

Dr. Inglesby

- Echoed sentiments expressed by Dr. Sosin and Dr. Groseclose
- Wished Drs. Burke and Austin best wishes in their future endeavors
- After thanking everyone for their participation, Dr. Inglesby adjourned the meeting at 3:01 PM

APPENDIX A: OPHPR BSC MEMBERSHIP ROSTER

Chair

Thomas V. Inglesby, MD
CEO and Director
Center for Biosecurity – UPMC
Baltimore, MD

Designated Federal Official

Samuel L. Groseclose, DVM, MPH, DACVPM
Associate Director for Science and Public Health Practice
Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention

Special Government Employee Board Members

Ruth G. Bernheim, JD, MPH
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Coleman F. Fung Professor
School of Engineering
Stanford University
Stanford, CA

Don Burke, MD
Dean, Graduate School of Public Health
University of Pittsburgh
Pittsburgh, PA

John R. Lumpkin, MD, MPH
Senior Vice President and Director Health Care Group
Robert Wood Johnson Foundation
Princeton, NJ

Ellen MacKenzie, PhD
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Professor of Psychiatry and
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The University of Texas Southwestern Medical Center
Dallas, TX

Ex Officio Members

US Department of Health and Human Services

RADM Nicole Lurie, MD, MSPH
Assistant Secretary for Preparedness and Response
Washington, DC

Lisa Kaplowitz, MD, MSHA (Alternate)
Deputy Assistant Secretary for Policy
Office of the Assistant Secretary for Preparedness and Response
Washington, DC

US Department of Homeland Security

Kathryn Brinsfield, MD, MPH
Assistant Secretary for Health Affairs and Chief Medical Officer
Washington, DC

Sally Phillips, RN, PhD (Alternate)
Deputy Director, Health Threats Resilience Division
Office of Health Affairs
Washington, DC

US Department of Defense

Col Steven P. Niehoff, DVM, MPH, DACVPM
USAF
Director, Global Health Surveillance
Force Health Protection & Readiness
Defense Health Headquarters (DHHQ)
Falls Church, VA

CDR Jesse Geibe, MD, MPH, MBA (Alternate)
USN
Defense Department Liaison Officer
Centers for Disease Control and Prevention
Atlanta, GA

Liaison Representatives

Association of Public Health Laboratories (APHL)

Christina Egan, PhD, DBSP
Chief, Biodefense Laboratory
Wadsworth Center
Albany, NY

Association of Schools and Programs of Public Health (ASPPH)

James W. Curran, MD, MPH
Dean, Rollins School of Public Health
Co-Director, Emory Center for AIDS Research
Emory University
Atlanta, GA

Association of State and Territorial Health Officials (ASTHO)

Marissa Levine, MD, MPH
Chief Deputy Commissioner
Virginia Department of Health
Richmond, VA

Council of State and Territorial Epidemiologists (CSTE)

Patricia Quinlisk, MD, MPH
Medical Director and State Epidemiologist
Iowa Department of Public Health
Des Moines, IA

National Association of County and City Health Officials (NACCHO)

Karen Smith, MD, MPH
Public Health Officer and Director of Public Health
Napa County Health and Human Services Agency, Public Health Division
Napa, CA

National Indian Health Board (NIHB)

Stacy A. Bohlen, MA
NIHB Executive Director
Washington, DC

APPENDIX B

**BSC Web Conference Attendance Roster
August 5, 2013**

NAME	AFFILIATION	AUGUST 5, 2013
Inglesby, Thomas	Chair and SGE	Present
Bernheim, Ruth	SGE	Present
Brandeau, Margaret	SGE	Present
Burke, Don	SGE	Ineligible ember
Lumpkin, John	SGE	Present
MacKenzie, Ellen	SGE	Present
Mitroff, Ian	SGE	Present
North, Carol	SGE	Present
Brinsfield, Kathryn	Ex officio (DHS)	Present
Kaplowitz, Lisa	Ex officio (HHS)	Present
Niehoff, Stephen	Ex officio (DoD)	Present
Bohlen, Stacy	Liaison (NIHB)	Absent
Curran, James	Liaison (ASPPH)	Absent
Egan, Christina	Liaison (APHL)	Present
Levine, Marissa	Liaison (ASTHO)	Present
Quinlisk, Patricia	Liaison (CSTE)	Present
Smith, Karen	Liaison (NACCHO)	Present