



## Minutes from the October 27, 2011

### CDC Advisory Committee to the Director

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**Advisory Committee to the Director  
Record of the October 27, 2011 Meeting**

The Centers for Disease Control and Prevention (CDC) convened a meeting of its Advisory Committee to the Director (ACD) on October 27, 2011, at the Arlen Specter Headquarters and Emergency Operations Center in Atlanta, Georgia. The agenda included reports from the Communications Workgroup; the Global Workgroup (GWG); the State, Tribal, Local, and Territorial (STLT) Workgroup; and Surveillance and Epidemiology Workgroup; as well as a Strategic Planning Session with the CDC Director.

**Welcome and Introductions**

Dr. Eduardo Sanchez (ACD Chair) called the meeting of the Advisory Committee to the Director, Centers for Disease Control and Prevention, to order at 8:30 a.m. He called roll of the ACD members and established that a quorum was present. He asked ACD members to disclose any conflicts of interest.

The following ACD members indicated conflicts of interest:

- ☐ Dr. Lynn Goldman disclosed that her department receives indirect funding through CDC.
- ☐ Dr. Alan Greenberg disclosed that his department receives indirect funding from CDC from the Association of Public Health Laboratories, Elizabeth Glaser Pediatric AIDS Foundation, District of Columbia (DC) Department of Health, and potentially through Abt.
- ☐ Dr. Herminia Palacio disclosed that her department receives indirect CDC funding through the State of Texas Health Department.
- ☐ Ms. Sara Rosenbaum disclosed that her department receives CDC funding.

Dr. Sanchez introduced three new ACD members: Dr. Herminia Palacio, Dr. Lynne Richardson, and Dr. Lynn Goldman. He also noted that Dr. George Isham and Dr. Anthony Iton were present in-person for the first time. Attendees from CDC and the CDC Foundation introduced themselves, and Dr. Sanchez thanked them for attending the meeting and for their efforts to protect the public's health in the United States and abroad.



### Director's Update and Discussion

Dr. Thomas R. Frieden (CDC Director) welcomed the group and thanked them for their time and energy. He encouraged the ACD members to provide unguarded comments and advice.

Regarding CDC's budget, Dr. Frieden indicated that in broad terms, an agency director's role in the public sector is two-fold: to secure as much funding as possible for the entity, and to ensure that the funds are spent as well as possible. The fiscal year (FY) 2012 federal budgeting process is underway. The continuing resolution (CR) will expire on November 18, 2011, and will be followed by another short-term CR. The United States (US) House of Representatives and the Senate are very far apart in their budget deliberations. They are especially divided on the Departments of Labor and Health and Human Services (HHS), including CDC.

The Senate has proposed \$7 billion in budget authority for CDC. The Vaccines for Children (VFC) Program adds \$4 billion, and CDC receives about \$2 billion from other agencies, bringing the agency's total budget to approximately \$13 billion. The Senate proposal increases CDC's budget by 2.5% over FY 2011. The Affordable Care Act (ACA) includes a Prevention and Public Health Fund, which is slated to be \$1 billion in 2012. The Senate proposal allocates 85% of that fund to CDC, with the rest allocated to other parts of HHS. The Senate budget includes increases for immunization, chronic disease, and Community Transformation Grants (CTGs), although the proposed model for the CTGs is different from CDC's model.

The House of Representatives has proposed \$6 billion in budget authority for CDC, which is 13% below the level for FY 2011. The House proposal eliminates the entire Prevention and Public Health Fund and includes specific and general cuts. The Senate proposes to eliminate three CDC programs: block grants for prevention; a youth violence prevention program, which is perceived to overlap with a Department of Justice (DOJ) program that focuses on incarcerated youth; and the lead poisoning prevention program. Lead poisoning has been decreased by more than 90% over the last three decades, but programs are still needed for surveillance, epidemiology, investigations, and case management. The House budget does not specify where the cuts should occur within the program areas. This situation is precarious, particularly given the reductions at the state and local levels. Today, 50,000 fewer people are working in state and local health departments than three years ago.



Dr. Frieden explained that he outlined five key priorities for CDC when he became Director. The agency was reorganized around these priorities, and they also provide a means for evaluating and tracking CDC's successes or failures. These key priorities include: 1) "Knowing better" through surveillance, epidemiology, and laboratory services; better support to state and local health departments; increasing impact in global health; using science to inform policies to promote health; and maximizing health.

The positions of Deputy Director for Surveillance, Epidemiology, and Laboratory Services and Deputy Director for State, Tribal, Local, and Territorial Services were created. In the area of epidemiology, CDC has strengthened the release and timeliness of information. CDC has also made information more relevant, including examining healthcare in a systematic way. A report on health disparities and inequalities was released. On the first Tuesday of each month, CDC releases *Vital Signs*, a publication that addresses key health trends in the United States.

CDC has re-launched and expanded the Public Health Associates Program (PHAP), which had not existed since 1993. In its history, PHAP focused on local health departments, and it cultivated most of the middle- and upper-level management at CDC and in many local health agencies. With the re-emergence of PHAP, a group of over 100 Public Health Associates are now in the field.

Regarding the priority to increase global health impact, Dr. Frieden observed that global health faces challenging times. Global health is good for America in many ways; however, he expects to hear the argument that "we can't afford things for this country, why should we pay for them for other countries?" The new Center for Global Health (CGH) and its ACD workgroup consider these issues.

The Associate Director for Policy, Andrew Rein, and his office are charged with finding ways to use science to inform policies to promote health. These initiatives include eliminating exclusions for HIV-positive people and helping with health reform and prevention. Science should guide and drive program and policy.

CDC maximizes health impact by identifying key "winnable battles" that can make a major health difference while saving lives and money. The winnable battles include tobacco control; nutrition, physical activity, and food safety; healthcare-associated infections (HAIs); motor vehicle injury prevention; and teen pregnancy prevention.

With regard to tobacco control, certain jurisdictions in California and New York City continue to implement tobacco control programs and observe declines, but overall declines have slowed or stalled. Increasing numbers of states are implementing smoke-free laws and increased cigarette taxes, but at the same time, efforts to roll back tobacco control are taking place. The Food and Drug Administration (FDA) is mandating graphic warnings on cigarette packs, and CDC works with them to provide scientific background and justification for their regulations. The tobacco



industry has optimized the amount of free or “crack” nicotine in cigarettes and smokeless tobacco. A 2009 bill freezes the tobacco industry’s ability to continue to “tweak” their products to make them more addictive. CDC’s laboratories are on contract with FDA to engage in critical work in monitoring compliance with the law. A national media campaign will be launched in the next few months.

In terms of nutrition, physical activity, and food safety, progress is being made in the healthfulness of school meals. The United States Department of Agriculture (USDA) will issue their final school meal guidelines, and improvements are also being made in Women, Infants, and Children (WIC) and food stamp policies. The ACA includes a nationwide law for food labeling. The area of food safety has seen both progress and challenges. Progress is being made in identifying and rapidly responding to outbreaks. CDC, FDA, and USDA collaborations are strong. The recent *listeria* outbreak in Colorado is an example of a success story in food safety. The Colorado Department of Health is one of 10 departments of health funded by CDC to conduct intensive outbreak and food safety work. They identified the outbreak within days of its occurrence, using old fashioned epidemiology, and worked to clear the contaminated goods from store shelves over Labor Day Weekend 2011.

Healthcare-associated infections are largely preventable infections that represent extremely high costs to society and individuals. Significant improvements are being made in this area. More than 5000 hospitals report to the National Healthcare Safety Network (NHSN). Declines of 5% to 10% per year are being observed in many types of infections. Electronic data submission capabilities are being expanded.

Regarding motor vehicle injury prevention, there have been noteworthy declines in motor vehicle crashes and fatalities over the years. These declines could be due to safer roads and safer cars, and graduated driver licenses (GDLs) have had a major positive impact on teen driver safety. Problems still remain with alcohol-impaired driving. Sobriety checkpoints and use of alcohol interlock systems for first-time Driving Under the Influence (DUI) offenders have been expanded. Graduated driver license laws and primary seatbelt laws are also being expanded.

Teen pregnancy prevention has been the most challenging of the winnable battles. It includes the mother-to-child transmission of poverty in large parts of the US. There have been slight decreases in teen birthrates; however, other countries have achieved much stronger declines over the past 40 years. Currently, the US teen birth rate is 5 to 10 times higher than many other countries. The variability within the US is enormous. Progress in this area would reduce health and social costs and would also contribute to reducing inequalities in society.





In terms of HIV prevention, the new Health Prevention Trials Network (HPTN) 052 trial has shown the tremendous efficacy of “treatment as prevention” in preventing the spread of HIV from one partner to the other. The test-and-treat model is validated as one component of HIV prevention. CDC has changed how they award their major HIV grant by realigning the funding to areas where the epidemic is most acute. This change will result in many states experiencing funding reductions, which will take place gradually over five years, but the state health officers understand the change and support it. CDC is also focusing on the demographic groups at highest risk. While heterosexuals and injection drug users continue to contract HIV, the driving force behind the HIV epidemic in the US is men who have sex with men (MSM). There are increases in HIV among MSM, particularly those under the age of 30. CDC also stipulates that 75% of HIV funding must be allocated to four core interventions that work, with the remaining 25% of funds allocated to evidence-based programs.

Dr. Frieden stressed that improvements in motor vehicle injury prevention, as well as the other winnable battles, save money as well as lives. An obese person costs \$1400 more per year, on average, to care for than a person who is not obese. A smoker costs \$2000 more to care for than someone who does not smoke. A person with diabetes costs \$6600 more to care for. The winnable battles not only maximize health, but also control costs.

He then highlighted major initiatives at CDC. The Million Hearts Campaign aims to prevent one million heart attacks and strokes over the next five years. The campaign encompasses many major initiatives in community and clinical prevention. It binds community and clinical prevention together in new ways. CDC is co-leading the campaign with the Centers for Medicare and Medicaid Services (CMS). The concept of the campaign is to reduce the number of people who need treatment and to improve the quality of care for those who need treatment. To address the first task, the campaign includes tobacco control, sodium reduction, and trans fat elimination. Improving treatment includes the ABCs: aspirin for people at highest risk, blood pressure control, cholesterol control, and smoking cessation. The ABCs are poorly addressed in the US. Programs that improve the ABCs have similar attributes, including focus so that everyone knows this issue is critically important, health information technology (IT), and team-based care. The goal is to reach 65% societal control of blood pressure and cholesterol. Health IT is growing quickly, and CMS is releasing strategies for increasing broad, team-based care.

Healthcare can make a significant difference in community health. For instance, cardiovascular mortality was cut in half in the US from 1980 – 2000. This reduction was due to community prevention and clinical prevention. Unfortunately, with the increase in obesity and the aging US population, the long-term decline in cardiovascular mortality is slowing. If the Million Hearts Campaign is successful, there will be 10 million more people with controlled blood pressure, 20 million more



people with their cholesterol controlled, 4 million fewer smokers, at least a 50% reduction in trans-fat intake in the population, and at least a 20% reduction in sodium consumption. The campaign may not save money, as it will require more treatment for more people. If they are successful, then money will be spent on preventing heart attacks and strokes rather than on treating people who are sick, so there will be more health value for the dollars spent.

The Million Hearts Campaign focuses on programs that can be scaled. The Community Transformation Grants (CTGs) cover more than 100 million people and focus on tobacco control, blood pressure control, and reducing obesity. No community has scaled up physical activity in a systematic way, however. There is no question that increased physical activity is a “wonder drug” and makes a big difference in people’s lives in nearly every area. Certain programs fall into a category of, “we know what to do, and we’re not doing it.” This category includes tobacco control, the ABCs, and other aspects of the Million Hearts Campaign. Another category includes “things that we need to do, but that we don’t have scalable, evidence-based ways of doing.” Physical activity falls into that category.

Another major trend at CDC focuses on prescription drug overdose, which is the only major cause of death that is increasing in the US. More people die from prescription narcotics and painkillers than from heroin and cocaine combined. There has been a six-fold increase in the last decade in the amount of drugs prescribed, and this rise is paralleled by increases in drug treatment admission, emergency department visits, and deaths. Drug overdose kills more people than motor vehicle crashes, and there has been a three-fold increase in opioid deaths. A few approaches may work to address this epidemic. These approaches include “doctor shopping” laws, Prescription Drug Monitoring Programs (PDMPs), or Medicaid programs that restrict patients to one doctor and one pharmacy. They are not addressing the problem as effectively as they could.

Dr. Frieden mentioned that the movie “Contagion” was great for CDC, and that added that the ACD subcommittees and workgroups have been very busy and helpful. The Public Health Ethics Subcommittee (PHEC) has addressed topics such as shortages in emergencies and controversial chronic disease programs. The Health Disparities Subcommittee (HDS) has shaped thinking about how CDC can better hire and mentor. They have also considered the National Prevention Strategy to ensure that disparities are represented. The National Biosurveillance Advisory Subcommittee (NBAS) has identified how the federal government can track important health trends and electronic laboratory reporting. The Policy Workgroup is getting started and will be important in helping CDC think about issues such as the new law that will require the Treasury Department to approve how non-profit hospitals maintain their non-profit status. The STLT Workgroup has provided detailed recommendations pertaining to how CDC can be more responsive and improve interaction. The Surveillance and Epidemiology Workgroup has considered healthcare surveillance.





## Discussion Points:

Regarding prescription drug abuse, Dr. Jack Lord commented on a new model for people with chronic pain. In this model, the prescription is not given to the patient; rather, it is delivered directly from the doctor's office to the pharmacy.

Ms. Rosenbaum commented on the challenges that lie at the intersection of clinical prevention and public health. Medicaid expansion in the ACA represents the greatest infusion of resources. States are more experienced in buying coverage and care for at-risk populations than anyone. She wondered about the steps that CDC could take concerning the Medicaid expansions, HIV opportunities, the Million Hearts Campaign, and other goals that are by nature clinical prevention, but that also feed into the population. She asked whether CDC has had discussions with the Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) regarding ways to allow health agencies to tap into Medicaid agencies as huge purchasers for populations that have been outside healthcare. This issue should be framed as a public health issue. There is unhappiness regarding the mandatory nature of the Medicaid expansion, but states are relieved because they are stretched to cover lower-income populations.

Dr. Frieden answered that CDC created an Office of Prevention Through Healthcare, and CDC is imbedding staff at CMS. The Million Hearts Campaign is the top priority of their partnership. Medicaid currently overwhelmingly serves women and children, but over the next three years, that population will change dramatically and will include people who need the ABCs of treatment and other preventive services. Their top focus is the ABCs, but there are other issues to consider. CDC is neither a regulatory nor an obtainment agency. CDC has the ability to help CMS and FDA do their jobs. For instance, CDC has helped FDA in tobacco as they produce regulations and develop data.

Dr. Benjamin Chu addressed the question of good health IT. Good information is critical for surveillance and chronic disease management. The ACA and the Recovery Act both provide streams that could boost IT. One of the meaningful use criteria is that it is optional to report key data points to public health agencies. Providers do not want the reporting to be too onerous, but the tool has been untapped for reporting meaningful information. The primary care medical home issue, with its team-based, proactive approach, is another major movement. CDC could be more purposeful about interfacing with these movements. CDC could influence what is reported and the format of the reports, as well as the rules of engagement and those who are getting primary care medical home designations. If these different streams report well, then they could provide a picture of the population and a driver for change.



Dr. Richardson added that monitoring and making progress on disparities is another area for consideration in health IT. There are some requirements for physician practices to collect data on patients' race, ethnicity, and language. It is not clear how strongly those requirements are applied. Practices are making huge investments in IT systems, and it is difficult to retrofit them, so getting involved early in system development will save money, time, energy, and lives. Regarding the intersection of community prevention and clinical prevention, she commented that emergency departments are crucial places where the intersection plays out. There are opportunities to identify individuals who are outside the care system. Small, but interesting, programs link emergency departments to real medical homes and community-based practices. It is not clear whether these programs are scalable models.

Dr. Greenberg observed that Dr. Frieden has been in the Director position for some years, having made the transition from a large, municipal health department to a federal agency. He asked Dr. Frieden to reflect on the strengths of CDC that were not apparent to him as an outsider, and also to share his challenges as CDC Director.

Dr. Frieden said he knew that the CDC laboratories were strong, but he has a new appreciation for how phenomenal they are, and how crucial they are to everything CDC does. Secondly, he has learned that the *Morbidity and Mortality Weekly Report (MMWR)* is a powerful vehicle. The *MMWR* is CDC's primary way to communicate with the public. He has been surprised at the difficult environment in Washington, DC. The CDC Director position is more different from his previous role than he had expected. The CDC Director sets direction and helps others with implementation. CDC is a large organization, and he works to make changes where they are needed. Further, CDC does not have direct interactions with service delivery.

Dr. Thomas Farley commented on the problem of opioid abuse. He was shocked by how drug companies market these drugs aggressively to practitioners. Policy changes could restrict these aggressive practices. He felt that the FDA should re-evaluate the labeling of drugs that are used for chronic, non-cancer pain. If the label did not permit such use, then physicians would have to go off-label to prescribe them, which may make them hesitate.

Dr. Dileep Bal commented that the CDC staff and priorities are excellent. Further, the winnable battles bring focus to their work. Regarding the CDC Director's job to obtain funds and spend them wisely, he commended Dr. Frieden for how funds have been spent. Regarding acquiring funds, Dr. Bal said that CDC has done a good job in reaching out to other federal agencies, encouraging collaboration and partnership. However, at some level, the agencies compete for resources. CDC must assert at all levels of the US government that it gives "a better bang for the buck." CDC has done a good job aligning dollars to epidemiology. He cautioned CDC to remain focused on the winnable battles. The magnitude of each of the



battles is not the same. He raised the example of lead poisoning efforts, which included leading changes to community norms and translating science to public policy in a unique way. The concept of using scalable, evidence-based programs is problematic. For instance, there is evidence to support policy interventions in physical activity and nutrition. Work in New York City in nutrition labeling is an example of such an intervention. CDC may be limited by Washington, but community norm change will be their legacy.

Dr. Frieden agreed that they need not just evidence-based practice, but also practice-based evidence. California and New York City have implemented programs that have been shown to work. If there is no proof that a program will have a population-level impact, then the program must be rigorously evaluated.

Mr. Sandy Climan commented on the importance of communication and changes in communication platforms. Communication is a dialogue and includes initiating change and action in communities. The tools of social media and dialogue put accurate and authentic information into the hands of people who can do something with it. Communication is not about scaring people, but rather about encouraging peer-based behavior change with long-term impact on the health of the population. He believed that private investment into technology-based medicine and medically-associated services will soar. CDC could have a role in those investments and could ensure that they have impact.

### **Surveillance and Epidemiology Workgroup Update and Discussion**

Kelly J. Henning, MD (Director, International Health Programs, Bloomberg Foundation) presented an update on the Surveillance and Epidemiology Workgroup, which is nearing the conclusion of its work. She noted that Dr. Frieden charged the Office of Surveillance, Epidemiology, and Laboratory Services (OSELs) with creating a surveillance report on tracking the impact of healthcare reform on prevention and healthcare. OSELs leadership initiated the project, developing an initial concept and potential indicators. The Surveillance and Epidemiology Workgroup was formed to provide consultation and suggestions on the report. They did not provide consensus recommendations, but rather feedback to the OSELs group working on the project.

A wide range of potential indicators were considered by CDC. The majority of the workgroup's process revolved around the indicators to be used for the report and to pare down the list to the indicators that were the most relevant and doable. The workgroup suggested that the report be refocused around the following key areas: 1) CDC priority health outcomes; 2) primary and secondary prevention services likely to be affected by the ACA; 3) population health measures, with persons or patients as the measurement focus, not providers or payers; 4) data sources should be available for reporting on a regular basis: workgroup members and CDC staff had "wish lists" that may not have had data sources available; 5) documentation of the proportion of the population receiving the recommended prevention services, or having the condition under control, reflecting appropriate



preventive care; and 6) provision of data to promote action by public health and other stakeholders that affect population health.

After reviewing the indicators, some workgroup members suggested that the report should focus on services listed by the ACA and recommended by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration (HRSA), and others. Some workgroup members advocated for a broader set of services, including management of blood pressure, cholesterol, and diabetes. Based on the workgroup comments, OSELS drafted the report, which included both primary and secondary prevention; some indicators in the ACA and some not; and chronic disease control. The report focuses on adult services and does not have a significant pediatric component.

The workgroup reviewed the draft report and provided comment, and CDC revised the report again. Most of the work was done by email and teleconference. The services addressed in the report include: aspirin therapy to prevent cardiovascular disease; control of blood pressure in adults with hypertension; screening for lipid disorders and control of lipid levels; control of blood glucose among adults with diabetes; screening for tobacco use, cessation counseling, medication, and cessation; screening for colorectal cancer; screening for breast cancer; assuring awareness of HIV-status among those infected; and vaccination against influenza in adults. Dr. Henning noted that a number of additional indicators were considered, such as depression screening, but data were not available for them.

CDC is completing its review of the report, and a consultation with HHS is ongoing. The document will be submitted as a supplement to the *MMWR* with an anticipated publication date of March 2012. After the report is published, the workgroup plans one more consultation to discuss public comment and discussion; stakeholder reaction to the report; impact of the report in shaping dialogue and action; and suggestions on future iterations of the report. The workgroup will be disbanded after that consultation, which will take place about one month after the *MMWR* is released. Because the members of this workgroup were selected specifically for this report because of their expertise, Dr. Henning is in discussion with CDC and ACD regarding topics that might be raised for future workgroup activity.



**Discussion Points:**

Ms. Rosenbaum asked how many state Medicaid programs will recognize aspirin as a covered benefit. Aspirin is an optional, over-the-counter benefit for adults. CDC might work with CMCS to ensure that aspirin can be covered without a co-pay and dispensed in a physician's office under current Medicaid policy and in Medicaid expansion. Otherwise, it is unaffordable.

Dr. Sanchez believed that the ACA includes new cardiovascular disease counseling through Medicare, which includes aspirin counseling. Partnership for Prevention was one of the advocates for that program. Partnership for Prevention also convened an Aspirin Task Force to address those issues, and they might provide insight into those questions.

Dr. Palacio asked for additional detail regarding the workgroup's decision to exclude pediatric populations from some of the measures. Particularly, blood glucose measures have long-term implications, and diabetes concerns are emerging in younger and younger populations.

Dr. Henning said that the workgroup's conversations regarding pediatric populations focused on immunization. They felt that these issues were beyond the scope of the report. She did not recall whether the workgroup discussed pediatric diabetes care and glucose monitoring, as their focus was on the ABCs and adults.

Dr. George Isham said that the report focuses on CDC priorities and on recommendations from other federal entities. He hoped to see the draft report and wondered whether there was a missed opportunity to systematically report services that are covered without copay in the ACA, which sets de facto standards and priorities for the country. The different federal agencies, such as USPSTF, ACIP, and HRSA, have different standards for evidence and different rules for transparency and process. There does not appear to be a coherent federal policy. There is an opportunity for CDC to describe the state of prevention and how prevention is addressed in the ACA, and then to address issues related to prevention and how the country attempts to measure prevention. Then CDC can highlight gaps, such as the indicators that do not have good measures. Items can be related to potential impact on healthy populations with a systems approach.

Dr. Sanchez commented that HealthPartners has been working with the National Commission on Prevention Priorities, which is part of Partnership for Prevention. They have considered the USPSTF and ACIP recommendations to categorize them by health impact and cost-effectiveness, looking at disparities in utilization by race and ethnicity and utilization rates. HealthPartners has a sense of where opportunities exist to improve.

Dr. Isham asserted that the surveillance report is important, but thought that more could be done.





Dr. Henning said that the workgroup also discussed the scope and breadth of the project. The exercise was to develop a report for the *MMWR*, and workgroup members had different opinions about how to approach it. Many members supported a broader piece of work, but there were constraints on the report's length and scope. The report supports the winnable battles and objectives of CDC. She agreed with Dr. Isham's comments.

Dr. Frieden added that this report is the first of such reports, and they can consider additional products.

Dr. Farley asked whether the indicators were based on whether data were already available. He asked about potential data sources that could be used.

Dr. Henning said that the first iteration included 50 items on the indicator list. As the list became smaller and more focused, the issue of whether data sources exist became more important. For example, depression screening and alcohol screening were on the original list, but data were not available for them. The list includes items for which data are available. CDC programs have written chapters related to the indicators and listed multiple data sources.

Dr. Goldman thought the report was exciting and said that she was glad to see the tie-in with healthcare reform, with CDC playing an important leadership role in steering healthcare reform toward prevention. CDC does not deliver the services, but can play a powerful role in their direction. She was inspired by the idea that the report could spur further activity. She would be interested in an effort to assess missed opportunities with children. Even though children have been covered under Medicaid and various state CHIP programs, CDC has proven that if clinicians follow the National Heart, Lung, and Blood Institute (NHLBI) asthma treatment guidelines, hundreds of emergency room visits and school absences could be prevented, which would also be cost-effective. Children are being inadequately cared for, and teen pregnancy is a winnable battle and a priority. Issues such as sexually transmitted diseases (STDs), substance abuse, and tobacco initiation are all important opportunities.

Dr. Henning thanked ACD for their comments and thanked the OSELS staff who assisted the workgroup.

Dr. Frieden welcomed any advice from ACD regarding how to make the Million Hearts Campaign "sing," including groups that should be included. Additionally, when the surveillance report is released in the *MMWR*, he asked that ACD provide their feedback and comments.

Dr. Stephen Thacker noted that they have already had discussions about creating alternate pediatric and adult reports.



With that, Dr. Sanchez dismissed the group for a break at 10:00 a.m. They reconvened at 10:14 a.m., and a quorum was present. Sylvia Drew Ivie, JD, joined the group by phone.

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

Alan Greenberg, MD, MPH (Professor and Chair, Department of Epidemiology and Biostatistics, George Washington University School of Public Health and Health Services), GWG Chair, presented an overview of the GWG activities to date. He reported that in spring 2010, Dr. Frieden established the GWG to analyze issues and make recommendations related to the new Center for Global Health. GWG focuses on three priority areas: 1) Strategy and Structure, 2) Science and Program, and 3) External Relations.

GWG meets twice yearly, on the day prior to the ACD meeting. Their first meeting was on October 27, 2010, and an in-person summary of the meeting was presented to the ACD the following day. The second GWG was held on April 27, 2011, and a summary of that meeting was presented to the ACD on their conference call on April 28. GWG's third meeting was held on October 26, 2011, and they have agreed to meet in person in April 2012.

GWG is comprised of ACD members, external experts, and international representatives. Travel has been a challenge for the international representatives, as they are senior in their Ministries and have difficulty leaving their countries. A number of CGH senior leadership members serve as key contacts for GWG.

As GWG was established, they asked CGH for guidance to define their operating principles. Non-ACD GWG members are not Special Government Employees. GWG meetings are not open public meetings, but minutes are required. GWG members provide informal input to CGH, which the CGH can choose to act on at its discretion; however, any work products must be submitted to ACD for review and approval. Additionally, any formal recommendations must be reviewed and approved by the ACD. GWG members can voluntarily agree to provide guidance to CGH between meetings. Changes in GWG membership are requested by the Chair and Designated Federal Official (DFO), with concurrence by the ACD DFO and CDC Director.

The CGH is a large center with five divisions and a number of major programs. Additionally, a number of important global health activities are scattered throughout other Centers, Institutes, and Offices (CIOs) within CDC. These activities are part of the DNA of the CIOs, as their programs address diseases both domestically and internationally. The CGH budget is \$2.4 billion, with 82% devoted to the President's Emergency Plan for AIDS Relief (PEPFAR) program for HIV/AIDS. CDC staff live in 40 presence countries, CDC is involved in 18 more non-presence countries, 387 CDC staff members are assigned overseas, and 44 additional staff detailed to international and other organizations.



GWG holds relatively short meetings so that workgroup members and CDC staff will focus on high-level, strategic issues rather than on program review. Equal time is scheduled for CGH presentations and discussion. Their first meeting oriented the GWG to the CGH and its goals. During their second meeting, GWG identified four themes: 1) CGH is impressive and is off to a strong start; 2) envisioning CGH potential: public health infrastructure and non-communicable diseases (NCDs); 3) there is a pressing need for a CGH strategic plan; and 4) partnerships and developing CDC's strategic voice. The second meeting also included presentations on NCDs, policy initiatives, global polio eradication; CDC's response to the earthquake and cholera response in Haiti; and summaries from other CIOs that work on global health issues. GWG's third meeting included updates from Dr. Frieden and Dr. Kevin DeCock, CGH Director. They also discussed the first draft of the strategic plan and updates on maternal and child health, engagement with other CDC CIOs, and health systems reconstruction in Haiti.

Regarding the first theme, CGH is impressive and off to a strong start; GWG observed that CGH has made extraordinary organizational progress in the past year. Five divisions have been integrated smoothly into the center. GWG noted outstanding CGH leadership and staffing. CGH has identified and established constructive linkages with global health activities in CIOs across CDC. CGH appears to be striking an effective balance between centralizing and decentralizing global activities at CDC. The center developed a critical Global Governance document that addresses many administrative issues. One of the highlights of this document is that it establishes one CDC Director or Representative per country to serve as a single point of contact. CGH has been embraced by other CIOs as having the capacity to raise the CDC global health profile; serve as CDC's global health voice; and coordinate in-country CDC global health activities.

The next theme focuses on the potential of CGH. In the area of public health infrastructure, CGH has a historic opportunity to be transformative, translating CDC's domestic legacy and model of capacity building and training with state health departments to a global setting with Ministries of Health (MOHs). The progress of developing public health infrastructure should be measured in decades, because it takes a long time to change the world. A majority of funding comes from vertical programs, but CGH should think broadly and not allow current fiscal challenges to lead to a lack of ambition or vision. GWG encourages CGH to capitalize on existing platforms that have been created by the vertical programs to build public health infrastructure. GWG further supports converting from emergency response to a strategic approach, defining critical elements of health systems, such as training, surveillance, epidemiology, operational research, laboratory, clean water, and sanitation. Clear goals and outcomes should be defined in collaboration with MOHs. The Field Epidemiology Training Program (FETP) is a critical tool. GWG also noted the opportunity to link developmental efforts with the efforts of other industrialized countries that are developing public health infrastructure.



In the area of developing CGH potential in NCDs, GWG acknowledges CGH's enormous capacity in infectious diseases. At the same time, there is a critical strategic opportunity to position CDC as a global leader on NCDs. There is strong leadership from the CDC and CGH Directors on this issue. Resources have been identified for the center to work in NCDs, and a cross-center NCD working group has been established. CGH created a position within the Office of the Director (OD) dedicated to NCDs, and there are plans to assign NCD staff overseas. NCD training will be integrated into FETP, and CGH has recognized the importance of building NCD surveillance systems. CDC has the opportunity to lead the exploration of the interface between infectious diseases and NCDs. CDC could accomplish a great deal by dedicating even modest resources and a small number of scientists to this area.

The third theme, the pressing need for a CGH strategic plan, was a large part of the agenda at GWG's third meeting. GWG had encouraged CGH to develop a strategic plan to articulate an inspirational vision of how the CGH will play a transformative role in global health and become "more than the sum of its parts." The plan should emphasize the "added value" of CGH; what CDC uniquely can contribute to global health; and how CDC differs from other global health organizations. CGH shared elements of the first draft of this plan at the GWG meeting.

The draft includes a vision, mission, guiding principles, and 13 strategic objectives that are divided into the categories of health impact, health security, and health capacity. GWG was impressed by the incorporation of a wide spectrum of CGH and other CIO global health activities into the draft plan. GWG encouraged CGH to continue to develop the plan with a focus on overarching, high-level, horizontal goals, such as coordination of CDC GH activities; public health infrastructure building; supporting vertical programs; and building CGH organizational capacity. Further, GWG emphasized the importance of an environmental scan, a SWOT analysis, and a partner analysis.

CGH has already included input from other CDC CIOs, and GWG suggested that they include other US government agencies, selected MoHs, and selected CDC Country Directors and civil society in the development of the document. The process of plan development and getting intra- and extra-CDC organizational awareness and buy-in is as important as the plan itself, especially since the center is so new. Further, it is important to include quantifiable targets and measures. The plan should reinforce how global health contributes to the domestic public health agenda and how CDC's involvement in global health is in the US national interest. There was discussion regarding whether this plan should be the CDC strategic plan for global health, or the CGH plan. GWG suggested framing the document as the CGH strategic plan for global health at CDC so that the plan is focused on CGH, but embraces the spectrum of CDC international activities. The



plan should be completed in the next three to six months, and GWG encouraged CGH to give the process priority.

GWG's fourth theme focuses on the importance of partnerships and developing CDC's strategic voice. Extensive progress has been made establishing internal connectivity with other CIOs, and it is important to articulate what CGH and other CIOs can do with each other that they could not do alone. Thus far, there has been less evidence of a strategic approach to developing external partnerships. No organizational unit within CGH is devoted to this task, although a position has been established within the OD. There is an opportunity to leverage the Global Health Initiative (GHI) to improve interagency relationships at headquarters and in-country. There is great potential for CGH to establish partnerships with the private sector. Numerous examples already exist at CDC, and there are opportunities to develop academic partnerships as well.

It is also critical to continue to develop CDC's strategic voice in GH. CGH should take advantage of the opportunity to monitor, package and communicate the full extent of CDC's global activities. GWG observed that CDC can be more comfortable contributing to public health rather than leading it. CGH should have a voice "at the high table," where decisions about allocations for global health are made with global partners, without losing its helpful stature. CGH needs a communications plan to develop a strategic leadership voice in global health. This process will be challenging, given the number of players in the field.

Dr. Greenberg reflected that GWG feels like a "team" and appreciated the workgroup members and CGH staff for sharing information and ideas.

#### **Discussion Points:**

Dr. Sanchez thanked Dr. Greenberg for the report and the effort that went into creating it. He asked for clarification questions and discussions, noting that the ACD would act to approve the summary meeting reports.

Ms. Rosenbaum asked whether ACD could see a draft of the strategic plan.

Dr. Greenberg replied that the draft is quite new, and GWG felt that the strategic plan was not yet complete. It embraces the vertical spectrum of global health activities, but GWG determined that it needs additional work on the overarching themes that will guide the future of the center.

Dr. Kevin DeCock said that ACD's time would be best used if they received a more developed draft of the plan.

Dr. Greenberg said that GWG can help CGH convene meetings to facilitate engagement with important voices to define CGH's strategic niche in global health.





Ms. Rosenbaum observed that CDC's approach to global issues is not different from CDC's approaches with state, local, tribal, and territorial offices. She asked how CDC decides where to go in the world.

Dr. DeCock answered that there are many different ways for CGH to reach out to the global community. There are also historical places where CDC works, such as in West Africa. PEPFAR and the President's Malaria Initiative are directive about where work takes place.

Dr. Greenberg noted that CDC has opportunities to build human, laboratory, and epidemiological capacity as the world develops. CDC's international role could parallel its domestic role with health departments.

Dr. Frieden said that this key insight from the first GWG meeting has been very helpful. Traditionally, that global role is shared with the World Health Organization (WHO). However, WHO has fallen on difficult financial times. CDC has a good partnership with WHO, but their overlap is interesting.

Dr. Goldman highlighted the importance of the horizontal goal of health systems strengthening. CDC could have a huge impact on the private donor community, which largely drives global health efforts. Private donors often focus on vertical programs, and it is important both domestically and internationally to better explain what health delivery systems are, and why they are needed. This effort should be cognizant of global trends in population, development, disease trends, climate change's effects on disease spread, workforce consideration, and other factors that will come into play in the next 10 to 20 years.

**Motion**

Dr. Goldman moved that ACD approve the October 2010 and April 2011 Global Workgroup summary meeting reports. The motion was approved unanimously.

**State, Tribal, Local and Territorial Workgroup Update, Discussion, and Request for Approval of Recommendations**

David Fleming, MD (Director and Health Officer, Seattle and King County), Chair, State, Tribal, Local and Territorial Workgroup (STLT), presented work products for ACD's consideration and approval. He indicated that the STLT Workgroup's charge is to provide **guidance and input to the Office of State, Tribal, Local and Territorial Support (OSTLTS)** to better position and support public health practice through the STLT community. Last year, the ACD requested that the workgroup generate recommendations regarding how to reform and improve the cooperative agreement mechanism, the primary way that CDC money flows to state, local, tribal and territorial health departments. The bulk of CDC financing is allocated to these entities. Many changes and developments in the past year (e.g., fiscal challenges, polarizing government, and decreasing trust in government) have increased the importance of these recommendations.



The STLT Workgroup includes ACD members as well as representatives from important constituencies in the practice community. A preliminary version of their recommendations was presented at the April 2011 ACD conference call. ACD asked that the workgroup move forward with these recommendations and to vet them within CDC. OSTLTS has facilitated the process of getting CDC input over the last six months. The workgroup considered CDC's feedback as they synthesized and organized the recommendations around four key concepts: 1) In order to reform the way that CDC does business, it is important to think about the valuable resources that CDC has for the public health community in the US. It is therefore important to engage the STLT community in determining how money is spent; 2) Given the dire financial situations, it is important to increase funding flexibility; 3) Grants are administered by a small number of people at the state and local level, so approaches across the funding mechanisms should be standardized to make their implementation as easy and efficient as possible; and 4) More investment is needed in quality improvement. There are always opportunities to do business better.

Regarding the recommendation to engage the STLT community, CDC should seek meaningful input of the STLT community in all significant aspects of the Cooperative Agreement process, such as making the business case; setting priorities within the available financing; determining goals and objectives; and selecting appropriate intervention and evaluation methods. In particular, this process should include, to the extent possible, an interactive process at the start of each granting cycle. Suggested implementation strategies, which emerged from a combination of input from CIOs and the STLT workgroup, include the following: 1) Develop a formal cooperative agreement feedback process at the beginning of each cooperative agreement at both the programmatic and policy levels; 2) identify and empower OSTLTS to act as the ombudsman for this process across the CIOs and with the Procurement and Grants Office (PGO); and 3) when there are a limited number of recipients, release a draft of a Request for Proposal (RFP) for comment, allowing all potential grantees an equal opportunity to provide input that could strengthen the Funding Opportunity Announcement (FOA).

The second STLT Workgroup recommendation focuses on increasing financing flexibility, which is critical in this time of decreasing resources. In concert with the STLT community, CDC should design and implement financing strategies for cooperative agreements that increase the flexibility to use funds in the most efficient and effective manner possible, while at the same time preserving accountability. With flexibility, there is a risk of block granting and decreased resources, which should be avoided. There is also a risk of supplantation with existing resources that are in play in jurisdictions. Strategies should include consideration of awards that can be bundled or linked across categorical activities within a jurisdiction; defining and funding both program-related and agency-wide infrastructure costs necessary for effective execution of grants; creating incentives and enabling the use of grant funds to include cross-cutting activities that allow the



National Prevention Strategy to move forward in an integrated way across cooperative agreements; and enabling cross-jurisdictional collaboration.

Examples of these strategies include gaining clarity about where CDC has the ability to add more flexibility versus what is fixed by law and distinguishing between historical practice and the law; defining necessary program-related and agency-wide infrastructure costs and provide at least partial funding for them in the cooperative agreement process; reducing the considerable administrative complexity of cross-jurisdictional approaches; and allowing jurisdictions to apply jointly for funding for key activities, given the need to consolidate health department functions and to consider regional services.

The STLT Workgroup felt that CDC should establish enterprise-wide consistent principles regarding the execution of cooperative agreements and facilitating integrated approaches. These principles should include common methods for granting and reporting across cooperative agreements; the balanced use of process and outcome metrics as well as performance measures so that there is consistency; a focus, particularly in declining budget environments, on achieving cross-agreement, public health system enterprise objectives that can be an element of each cooperative agreement; a standardized approach to developing and using innovative approaches and other best practices which are not yet firmly evidence-based; and a simple, quick mechanism for resolving questions about expenditures of grant funding or other contract-related questions without fault or penalty.

Example strategies for this recommendation include developing standards for what is meant by “evidence based” or “science-based,” including an enterprise-wide framework for “grading” of the different levels of evidence; developing a mechanism to enable effective, objective resolution when PGO guidance conflicts with good, practical, programmatic sense; developing a CDC project officer manual that outlines expectations across the different cooperative agreements and includes standards such as the types of questions that can be answered by a project officer versus PGO, or timelines for resolution of different types of questions; and requiring on-going reassessment of grant strategies based on changes in nearer-term outcomes.

Quality improvement is a general shortcoming of the public health system, and investment is needed. Working with the STLT Community, CDC should develop and implement a more robust and proactive system to assure quality improvement in the conduct of cooperative agreements. This effort should include development and monitoring of early performance indicators; a project officer “team concept” with broad competencies in grants management and technical assistance, including better knowledge of current and emerging best practices in the field; better access to external and peer-to-peer expertise; and intellectual and financial support of public health department accreditation as a key means for assuring quality improvement at the STLT level.



Examples of quality improvement strategies include routinely working with grantees, after completion of a grant, to collaboratively assess both grantee and CDC performance in terms of what worked and what did not work; working to ensure that project officers have expertise in both grants management and technical assistance; conducting reverse site visits of CDC programs by the STLT community; allowing accreditation incentives and allow documentation to be submitted with a grant proposal in lieu of other forms of grant documentation; and routinely soliciting STLT feedback on project officer and CDC support performance.

Dr. Fleming asked ACD to consider approving these recommendations during this meeting. The STLT Workgroup will then encourage CDC to develop a time-phased, measurable plan for implementing the recommendations. OSTLTS has agreed to report progress to the STLT Workgroup, which can then report to ACD. Further, objective measures should be developed to measure success.

**Discussion Points:**

Dr. Sanchez thanked the STLT Workgroup members and the OSTLTS Director and staff. These issues have been in the field for some time. This initiative was launched in the spirit of partnership with STLT health departments to move the enterprise of public health forward in a systematic way. He invited new ACD members to join one of the workgroups or subcommittees.

Dr. Bal participated in the STLT Workgroup and commended Dr. Fleming and Dr. Judy Monroe on their work. He agreed with most of the recommendations, but expressed concern regarding the second recommendation on flexibility. The pros and cons of increasing flexibility are obvious—funding should be based on local priorities rather than on edicts from Washington. Conversely, in these lean fiscal times, there is a penchant at the local and state levels to prefer to receive federal monies with no requirements attached. He felt that the recommendation should stipulate that the bulk of funds awarded should focus on the winnable battles. The winnable battles will bring the most “bang for the buck,” and all of the states will have a similar focus. He acknowledged his bias, as he comes from a background in chronic disease control, but he preferred that CDC set priorities rather than state and local entities. Most of the STLT Workgroup members are state and local health officers, and they wanted discretion over how funds were spent.

Dr. Frieden observed two issues to address: 1) the issue of flexibility concerns how “frictionless” work is; and 2) broad-banding or block granting. CDC has been frustrated for years by the way their budget comes from Congress. CDC has 173 different budget lines, and they have pushed to reduce that number by combining budget lines. He believes that while 173 budget lines is too many, the effort to combine them is a mistake. Block granting programs is “a prelude to a cut.”

Dr. Fleming agreed, pointing out that the language of the recommendation and the provided examples indicate that the workgroup suggests that bringing more flexibility to the grant process would allow for better cross-jurisdictional collaboration and/or financing. There are ways to use these grants in more efficient ways by agreeing on an outcome and being held accountable for it. The workgroup was opposed to the notion of block granting and framed the recommendation to encourage other elements of flexibility, as the current means of financing are constraining.

Dr. Bal agreed, especially with the inter-jurisdictional aspects of the recommendation and examples. He reiterated that the major focus should be on the winnable battles, if the battles are to be won.

Dr. Lord suggested that the recommendations include an overt set of statements to encourage innovation as an explicit part of the process. A corresponding point to consider would be language honoring values.

Dr. Fleming replied that the workgroup discussed the line between innovation and doing programs with no evidence that they work. The workgroup decided to recommend the establishment of best practices, assuming that most of the funding will go toward best practices, and recognize the need for innovation and enable innovation within the context of a design that allows for rapid assessment of effectiveness.

Dr. Lord said that often, a too-strong focus on success leads to missed opportunities along the way.

Dr. Chu addressed the question of accreditation of public health departments. The core of whether cooperative agreements work hinges on the capabilities of agencies to deliver on their priorities. He asked why there was not more of an effort to define the core competencies of public health agencies and to assure that the infrastructure is functional and can deliver. Offering flexibility to an organization that is focused on priorities and that has accountability measures is different from giving flexibility to any organization. He wondered whether they should emphasize an outline of real core competencies and how to assure a quid pro quo with flexibility.



Dr. Fleming said that the STLT Workgroup's suggestions for future work relate to that question. Accreditation is a major issue for public health, particularly at the local level. Core competencies have not been well-defined.

Dr. Frieden said that an accreditation process at the state and local levels has just been launched. Their challenge will be to make sure the process is useful.

Dr. Lord said that this work and the global work both would benefit from the application of International Organization for Standardization (ISO) standards across all platforms. This approach moves away from the individual accreditation process and allows for an international framework of work processes and metrics.

Ms. Rosenbaum said that these issues and problems affect many grantees of federal awards. It will be important to separate the areas over which CDC has autonomy from the grants and cost accounting principles across the federal government. Public health issues could give traction to the dialogue that has to occur between the Office of Management and Budget (OMB) and HHS. The public health issues illustrate where common accounting and reporting principles work at cross-purposes with being able to develop content expertise, disciplinary expertise, and common management practices. It should be possible to work across funding sources, and when it is not possible, it is because something is wrong in cost accounting principles and grant administration.

Dr. Goldman recalled problems with wasted effort in reporting the same information multiple times. She did not like the idea of block grants, and the recommendations should not sound like support for block grants. CDC could be creative and create a common reporting system for several small grants, streamlining the grantees' work and bringing them flexibility.

Dr. Sanchez noted that their first aim is to improve health, the second is to improve quality, and the third is to assure administrative efficiencies that will allow for dollars to be used more effectively to improve health and improve quality.

Dr. Fleming said that the STLT Workgroup seeks ACD's approval to continue their work. The public health system in the US needs to be transformed. In this time of budget reductions, health departments are asking for guidance about priorities. Certain core competencies need to be identified, protected, and expanded. The Robert Wood Johnson (RWJ) Foundation is engaging in a process to get initial consensus on directions for the public health system and governmental public health departments. It will be important to take advantage of that process, working with OSTLTS and ACD to craft clear recommendations for what the public health department of the 21<sup>st</sup> Century needs to look like. They can then do a better job of integrating the various financing and technical assistance mechanisms that CDC has. The next product of the STLT Workgroup is proposed to be practice-based consensus regarding public health system enterprise-wide priorities in this time of reduced budgets.



**Motion**

Dr. Bal moved that ACD adopt the STLT workgroup recommendations and that ACD approve that the STLT Workgroup continue to partner with OSTLTS to provide the ACD with updates on CDC's progress in implementing those recommendations. Additionally, the STLT Workgroup should continue working with OSTLTS to develop supplemental recommendations concerning the challenge of trying to do public health in a challenging financial situation. Dr. Goldman seconded the motion.

**Discussion Points:**

Dr. Bal offered an amendment to the second recommendation. He suggested that the recommendation specify that within financing flexibility, the bulk of funds should focus on the winnable battles.

Dr. Sanchez said that flexibility is not carte blanche, but takes place within a context of prioritizing how dollars are spent, and spending them wisely. The workgroup concluded that the lack of flexibility has hindered what makes good public health sense. Dr. Fleming agreed.

Dr. Greenberg observed a disconnect between the way CDC funds HIV/AIDS prevention, which takes a more proscriptive approach to how health departments use the funding, and this recommendation. The approach can either be proscriptive and require evidence-based interventions, it can give local entities flexibility, or it can combine both.

Dr. Sanchez offered the example of STD and HIV screening programs, which are very different. They may have traditionally been funded separately, where the processes can work in parallel in many instances. All work should be driven by science, and there should be expectations of outcomes. There should be a way to remove administrative burdens, given that multiple programs might have the same clients or patients.

Dr. Frieden suggested that the recommendation focuses on increasing flexibility as long as the work promotes the achievement of defined, specific, and agreed objectives.

Dr. Fleming concurred, adding that they do not suggest having the flexibility to address problems that are not priority problems, but flexibility to use the financing that is available for those problems in a way that is most efficient and effective. For instance, two separate jurisdictions could co-fund an HIV testing center.

Dr. Beth Bell offered the examples of the Public Health Preparedness Grant and the Epidemiology and Laboratory Capacity Grant. They are considering ways to



share metrics where the outcome is the same. For example, one outcome is how quickly specimens are submitted for uploading to PulseNet to investigate foodborne outbreaks. This outcome affects preparedness, it shows readiness, it is relative to the objectives of the preparedness grant, and it also relates to CDC's responsibilities pertaining to preventing and controlling foodborne outbreaks. Flexibility is not about having less accountability, but about finding shared metrics and outcomes that are consistent with the purposes of the grants.

Dr. Frieden proposed amending the recommendation to read "in order to achieve defined and agreed outcomes."

**Motion**

Dr. Bal approved of the amendment and moved that the recommendations be accepted with the amendment, and that the other recommendations be approved. Dr. Lord seconded the motion. The motion was approved unanimously with no abstentions.

The approved recommendations are as follows:

- ☐ CDC should seek meaningful input of STLTs in all significant aspects of the cooperative agreement process, such as making the business case; setting priorities; determining goals and objectives; and selecting intervention and evaluation methods. This input should include an interactive process at the start of each granting cycle.
- ☐ In concert with the STLT community, CDC should design and implement financing strategies for cooperative agreements that increase the flexibility to use funds in the most efficient and effective manner possible in order to achieve defined and agreed outcomes, while at the same time preserving accountability. Strategies should include consideration of awards that can be bundled or linked across categorical activities within a jurisdiction; define and fund both program-related and agency-wide infrastructure costs necessary for effective execution; create incentives and enable use of grant funds to include cross-cutting activities that allow the National Prevention Strategy to move forward; and enable cross-jurisdictional collaboration.
- ☐ CDC should establish enterprise-wide consistent principles regarding the execution of cooperative agreements. These principles should include common methods for granting and reporting; the balanced use of process and outcome metrics as well as performance measures; a focus on achieving cross-agreement, public health system enterprise objectives; a standardized approach to developing and using innovative approaches and other best practices which are not yet solidly evidence-based; and a simple, quick mechanism for resolving questions about expenditures of grant funding or other contracting related questions without fault or penalty.

- ❑ Working with the STLT Community, CDC should develop and implement a more robust and proactive system to assure quality improvement in the conduct of cooperative agreements. This should include development and monitoring of early performance indicators; a project officer team with competence in grants management and technical assistance including knowledge of current and best practices in the field; access to external and peer-to-peer expertise; and intellectual and financial support of public health department accreditation.
- ❑ To augment these recommendations, the STLT Workgroup will work with OSTLTS on the following issues and present recommendations to the ACD at the April 2012 meeting: 1) Budget deficits and ACA are driving the need to transform public health practice; 2) health departments are asking for guidance from CDC for navigating the future; and 3) the Robert Wood Johnson Foundation is engaging in a consensus project to provide recommendations on these issues.

### **Communications Workgroup Update and Discussion**

Dr. Frieden explained that the ACD expressed interest in creating a workgroup on communication, as they recognize that communication is critical to their success. The workgroup was not formed after the last meeting, and they should think about how best to proceed.

Katherine Lyon Daniel, PhD (Acting Associate Director for Communication, CDC), presented an update on the progress of, and need for, a Communications Workgroup. CDC communications leadership is in transition. She presented activities and accomplishments of the past year. There are a number of challenges regarding what and how CDC communicates. Their most recent priority has been to communicate the value of CDC's work and the importance of supporting it. Given the current economic climate, this message will likely remain their most important priority for some time.

A dedicated team of communication professionals from across the agency developed core messaging about CDC's work. They have identified spokespeople, trained them on the messages, created opportunities for them to speak, launched a website, gathered supporting stories and economic data to support the points, created a media and social media outreach plan; and are working to deliver on the plans.

The core message is that CDC's critical value is working 24/7 to save lives, protect people, and save money through prevention. Other messages include:

- ☐ CDC is committed to keeping Americans safe from health, safety, and security threats, whether foreign or domestic; chronic or acute; curable or preventable; by natural disaster or deliberate attack.
- ☐ CDC applies groundbreaking health and medical research and real-time emergency response to keep people safe, healthy, and secure.
- ☐ CDC puts science into action to save lives and advance the health of Americans to ensure a productive and secure nation.
- ☐ CDC works continuously with state and local health partners, providing them with the tools and guidance and support they need to handle a variety of health threats.
- ☐ CDC's work overall demonstrates that the US cannot afford to stop investing in public health and in prevention, because preventing health problems is fiscally smart, morally sound, and entirely possible.

CDC has also developed a more robust social media strategy. They have completed internal consultation on the process of how to best integrate the myriad of social media activities occurring around the agency and how to tie it into CDC's overall health communication planning. They have used online collaborations to promote multiple communication issues. One example of this approach is the Million Hearts Campaign, which uses all of their tools for communication and dialogue to draw people in.

CDC can do more in these areas, particularly in prevention messaging and the need to go further in the social media space. Dr. Lyon Daniel noted that CDC's brand is strong in science and credibility, and they do not want to change their brand. She described an example of marketing that Coca-Cola has developed to raise funds for a polar bear habitat and that will use people's emotions to bring attention to issues and therefore raise support for the endangered bears—and for the product. A two-way dialogue from CDC will better capture people's hearts and minds.

In the past year, CDC has also developed a fresh and more aggressive approach to news media placement. The film "Contagion" is an example of this effort. CDC supported the overall content and engaged in over 80 interviews in a variety of outlets. Another example is the new monthly release of *Vital Signs*, which shares clear information and a call to action. They are looking for other opportunities to be more proactive.





In response to requests from communities, CDC developed and launched a gateway that links communication and social marketing resources at CDC for practitioners. These resources are available for practitioners as they do their health education in the field. This gateway is targeted to a narrow audience, but it has received about 100,000 hits since August 2011.

If the ACD decides that a Communications Workgroup is still relevant and necessary, then they should identify two ACD members to serve on the group. They should additionally decide how to proceed and provide advice and support.

Dr. Frieden added that a great deal of work in the past few months has focused on the best way to position CDC and the best words that will work across a broad spectrum of individuals. Some messages have resonated more than others. “24/7” resonates, as does “keeping Americans safe from threats” more than notions of preventing or protecting. CDC’s long-term theme has been “safer, healthier people.” They have good guidance about how to speak about CDC, but more challenging communication issues remain, such as how to share messages through various outlets. CDC does well compared to other government entities, but there is potential to reach more. They should not underestimate the potential of new media or the continued power of traditional media.

#### **Discussion Points:**

Given the CDC Director’s role in helping to acquire resources, the challenges of working in Washington, and the importance of engagement, Dr. Greenberg wondered about CDC’s ability to engage with and influence decision-makers by “hitting them from multiple angles.” These approaches could be at the local and community levels or academia. He was concerned about how to engage with decision-makers and spur them to action.

Dr. Frieden said that their engagement efforts have strengthened in the last six months, both in sharing consistent messages and in listening to people’s concerns and addressing them. They need to build partnerships and ensure that they are all communicating.

Dr. Iton supported the need for a Communications Workgroup, given the pressing challenges, and indicated his interest in participating on the Communications Workgroup rather than the STLT Workgroup. (Note: Dr. Iton subsequently decided to remain on both workgroups.) CDC has multiple audiences, but their primary audiences shape their messages. He recalled a comic book about zombies that CDC is working on, and he applauded this work. CDC has a great story to tell, and they should recognize that the story is told differently to different audiences. Therefore, it is important to discuss and define the primary audience. State and local partners are critical, and he appreciated CDC’s dialogue with them. Messages should reach audiences that have the most power to influence CDC’s future.



Dr. Frieden said that Congress sets CDC's budget based on the President's proposal. They also set the budget based on what the public thinks of it; what they hear from state legislators, mayors, and governors; and input from academic institutions and advocates. Programs that may have relatively limited impact, but strong advocacy groups, can be more powerful than programs with huge potential impact, but less-effective advocacy. The CDC budget is an aggregation of different budgets and the products of different interest groups. It is challenging to parse their messages. The media landscape contributes to the political landscape, which contributes to CDC's ability to work.

Dr. Isham divided CDC's communication into three areas: 1) cutting edge tactics and edgy approaches; 2) promotion of CDC as an institution; and 3) communications challenges that public health in general faces in linking public health's value to the community. Linkages need to be made to national defense, the economy, and well-being. Public health needs a constituency that will fight for it. Finally, they must consider how public health is perceived in the political debates between extreme right and left factions. The perception that public health is on the political left is problematic. CDC speaks for public health, and he hoped that they would put effort into how to communicate the value of public health both for CDC and for all of the public health establishment.

Dr. Lord said that communications should remain a standing item for the ACD if they choose not to create a workgroup. He addressed the value of the film "Contagion" and the value of showing the public what CDC does in terms that they relate to, as opposed to terms that public health professionals relate to. The proof of CDC's value is in its impact on people's lives. CDC must therefore fundamentally engage people in a dialogue, as opposed to just sharing information. Further, the public tends not to focus on standby capacity in any domain. Much of CDC's work is in a standby capacity, and it may be useful to depict what would happen if there were no CDC. The "what would happen" question could powerfully engage people and help them understand CDC's contributions.

Dr. Fleming said that public health has struggled with marketing for some health. It is interesting, but not surprising, that the messages that appeal to CDC's ability to respond to external threats are the messages that grab attention. He encouraged CDC not to stop with those messages, however. Even though people gravitate to those ideas, CDC's problems include tobacco, healthy eating, active living, health disparities, and other concerns. They must not fall into a trap by marketing themselves at a high level based on what people expect and not communicating what public health actually does. After people are hooked, the next "drop-down" level of communication should help people appreciate and understand that most of the value of public health in the US is in preventing causes of death and disability that are under their control.

Mr. Climan said that many groups in addition to CDC want to reach that “drop-down” level of communication and understanding. Corporations are self-insuring and are taking radical steps to bring costs in line. CDC is marketing personal health, and the tools that they need to use will be complex to evaluate. For instance, Dr. Sanjay Gupta decided to remain with CNN and not become Surgeon General, because he could make more of an impact with CNN. They should think proactively about a regular thought process in light of massive marketing regarding personal responsibility in health, and much of that marketing will not come from traditional sources. CDC needs to place itself in this picture and make radical changes about how people view CDC. CDC has assets that they have not chosen to activate. He suggested that they inventory their assets and decide how and when to deploy them appropriately and in impactful ways.

Dr. Sanchez observed that conversations about communication should continue. Dr. Iton expressed interest in joining a workgroup on communication, and Dr. Lord, Dr. Isham, and Mr. Climan also indicated interest. Dr. Sanchez suggested that those interested parties work with Dr. Lyon Daniel to think about how best to address these issues and how to continue.

Dr. Lyon Daniel thanked the ACD for their guidance. Dr. Farley asked for a summary of CDC’s communication activities and the messages that were developed. Dr. Lyon Daniel said that she would provide that information.

Dr. Greenberg suggested that they form a formal workgroup and hear outside input.

Dr. Sanchez replied that since there was still some transition at CDC, it might be best to get a sense of the scope of the issues through informal means.

Ms. Carmen Villar said that the ACD voted to establish a workgroup, so it exists and can be populated.

Dr. Sanchez said that the conversations with CDC staff and the four interested ACD members could consider whether outside people should be invited to participate as a workgroup. If so, they have the “blessing” of the ACD to do so.

### **Strategic Planning**

The meeting resumed at 1:21 p.m. following a lunch break. Dr. Sanchez called roll of the ACD members and established that there was a quorum. He asked for additional disclosure of conflicts of interest. The following ACD members indicated conflicts of interest:



- ☐ Dr. Chu currently chairs the Legacy Foundation, which has linkages to CDC funding.
- ☐ Dr. Sanchez is on the Board and is the incoming Chair of Partnership for Prevention, which receives CDC funding for a host of activities, including sexual health.
- ☐ Dr. Bal is funded by CDC for prevention work; some of his staff is paid by CDC.
- ☐ Dr. Isham said that his research foundation receives grants from CDC.

Dr. Frieden shared CDC's latest thinking regarding likely trends and what CDC should do differently to plan for the future. Epidemiologic and demographic trends indicate continued growth and increasing diversity in chronic diseases. CDC will be successful in reducing heart attack and stroke. More public health problems such as diabetes, Alzheimer's disease, and arthritis will increase. Infectious diseases will remain a problem, with increasing drug resistance bringing challenges and new antibiotics. End-of-life care and care of the very old will be significant issues.

Environmental changes such as climate changes, pollution, and fine particulates will be concerns. The water supply is also a concern, as increasing numbers of communities in the US have either insufficient water supplies, or water supplies of questionable cleanliness. The infrastructure, created a century ago, is crumbling. Transport and agriculture sectors play a role in health. They face challenges with energy and pollution.

The US approach to global health and the changing global health landscape are important to consider for CDC's future. Questions remain about where global health should sit, and the best models for global health. There have been huge increases in the number of partners involved in global health. Foundations, bilateral donors, multilateral organizations, and new entities have emerged, making the global health picture more complex.

The public health workforce is aging, and fewer new workers join the field. They must grow the public health workforce and ensure its vibrancy. Fiscal constraints also must be considered. It is not known how much longer the current fiscal situation will last, or whether indefinite fiscal restrictions must be faced. States may continue to cut drastically, and some may implode. Some states have already proposed eliminating their health departments.

Healthcare structures are changing. It is not clear whether the ACA will survive legal and political challenges. Further, the impact of increased coverage on public



health is not known. Healthcare facilities run by public health agencies are threatened. Health IT is expanding rapidly, and CDC should find ways to get prevention value from those advances. Accountable care organizations and bundled care are leading to the internalization of incentives so that there are real goals for improving health. Team-based care is a major potential issue. Quality will be higher, costs will be lower, and jobs will be created. There are many barriers to team-based care and the use of non-professionals, however, including the mentality of the scope of practice laws in the states. IT brings opportunities to increase efficiency and to have two-way communication. Confidentiality, loss of data, and data integrity concerns are potential threats.

One of the major narratives in the years to come will be “the nanny state,” and CDC’s strategic thinking must take into account the state of politics and the public mood. Dr. Frieden hoped that they could discuss responsive government; that is, government that responds to what people expect. People expect not to be harmed by forces outside of their control. They expect to live in communities that are supportive of healthy decisions. They need to avoid the pitfall of not emphasizing personal responsibility, as there is not a conflict between personal responsibility and societal responsibility—the two are synergistic. If people want to live long, healthy lives, then they have a responsibility to make good, healthy choices. Society and communities have the responsibility to make it easier for people to make the right choices.

In the upcoming 2012 elections, it is likely that the makeup of the Senate will shift to a Republican majority. CDC is a science-based, non-partisan organization. At the same time, potential realignments in 2012 have implications for what might be funded and how CDC may have to retrench.

The communications landscape is changing quickly, bringing a cacophony of voices as well as opportunities to reach people and learn from people.

Dr. Frieden asked ACD to share thoughts on other major trends that should be considered and aspects of the trends he described that should be considered. Also, he asked them what CDC should do now in order to be well-positioned to address these trends.

#### **Discussion Points:**

Dr. Fleming offered two additions to the list of trends. The unequal distribution of wealth in this country is leading to profound problems with increases in health inequity, not just at the individual level, but at the community level. They should think about the nature of interventions that will make a difference in those poor communities. Additionally, the public health workforce is not only aging, but also the skills and training needed in NCDs and health disparities are undergoing changes. Policy support, advocacy, connections in the community, are all areas that need strengthening.





Dr. Farley addressed the issues of communication and the “nanny state.” The media has been critical of initiatives in New York, but polling data indicate that a large percentage of New Yorkers are supportive of the initiatives, particularly those concerning food. He suggested that they should not be deterred, because people like it when the government actively creates a health environment. Perhaps they should do more polling and be more assertive about publicizing the results of the polls in order to embolden their political supporters. Regarding IT, Dr. Farley observed that aggregated electronic health records could be the surveillance system of the future. Current surveillance systems are not good at measuring the things that really matter to health. Electronic health records present the opportunity for a population-based tool, and CDC could lead that movement. He observed that the United Nations meeting presented four important behavioral issues: smoking, diet, physical activity, and alcohol. Alcohol is almost never mentioned as a public health problem in the US, but it is a problem.

Dr. Sanchez added that the National Commission on Prevention Priorities (NCPPI) has concluded that alcohol screening in the clinical setting is a cost-saving intervention. Despite the compelling evidence base, the intervention is not being done. Alcohol screening in the clinical setting, with referral to treatment, can change the trajectory of alcohol abuse.

Dr. Farley said that the model of tobacco can be applied to alcohol at the population and policy levels.

Dr. Iton said that New York has been a leader in making the case for public health prevention strategies. On the issue of the distribution of wealth, they struggle because of the tendency to frame issues from a deficit perspective. He has struggled with how to craft a message that speaks to these issues while giving a hopeful picture. The loss of the middle class has impacted fiscal, educational, and social policies. The decline of the middle class is associated with trends that have adverse health impacts. People can harken back to a time when the middle class characterized the country and associate those times with hopefulness and vigor, and they may identify more closely with these concepts than epidemiological or demographic concepts. He reflected on his experience in public health academics. The University of California, Berkeley, has seen a large demand for public health courses at the undergraduate and graduate levels. He did not understand why there is simultaneously a shortage of workforce. Entities such as insurance companies, pharmaceutical companies, and global health organizations may be attracting the public health workforce, as opposed to governmental public health infrastructure.

Mr. Climan commented on the evolution of the educational platform. There has been an infusion of science and thought into learning through traditional media as well as new media. The next generation will learn and communicate in highly interactive ways, starting at young ages. There are opportunities to layer

communication to layer messaging into the landscape of how people learn and entertain themselves.

Dr. Henning said that epidemiology and surveillance are core activities for public health and CDC. The ways in which surveillance data are gathered will change, and she suggested that CDC think through new ways to do surveillance and how to continue to remain a leader. In global health, she encouraged CDC to think about non-traditional partners such as trade, finance, and other aspects of the US government that have impacts on public health. Further, the GWG discussed how examples from low- and middle-income countries could be applied to the US. She agreed that alcohol does not receive focus as a public health problem.

Dr. Richardson endorsed the comments regarding health equity and social determinants of health. These issues will have implications for the kinds of interventions that need to be developed and the indicators that need to be measured and followed in order to improve health. She agreed that electronic health systems would be the surveillance system of the future. An on-going risk is the juxtaposition of the “obsession with privacy” with the opportunities for public health to use data in new ways with new systems. Issues of exemption, informed consent, uses of non-clinical specimens and data, and other concerns for practice-based evidence and health services research should be reexamined. In order for public health to be able to use data from these new systems to improve the health of the public, they will need a counter-campaign to address privacy concerns.

Dr. Isham commented that the biggest risk for CDC and public health is the thought models that exist. Fiscal constraints may be cyclic, but they also may lead to long-term structural changes in the economy and the relative position of the US to other countries. The 50 years after World War II may have permitted Americans to be somewhat wasteful in the way we think about government and society in general, as opposed to an environment in which there are tough international competitors and international businesses. A mentality of scarcity can result in a behavior set that leads to a generation of leaders and institutions being “wiped clean” and replaced. CDC should think dynamically about these changes as a challenge and an opportunity to reinvent itself on a grand scale, beginning with thought models and culture within the organization. Many people may be strongly committed to the government’s objectives but wonder why the government does not do things differently and what will make those changes possible. When people see unresponsiveness in government, they may “sit on the sidelines” while more radical voices take over. The US is in a time of transition in public health and healthcare, imagining how to do much more with much less.

Dr. Bal suggested poverty and education as other issues to consider. The interconnectedness of each of the issues on Dr. Frieden’s list is key, and poverty and education affect each of the issues. Income disparities affect public health in elemental ways, particularly because the decision-makers are at the top of the economic scale, while those who need care are at the bottom. Similarly, those at



the top of the education scale make decisions that affect those at the bottom. He referred to the Coasian Economic Theory regarding externalities that there can be totally unrelated, unplanned effects of actions. Public health is affected at many levels. Of necessity, there are silos in public health. For years, the world was divided into communicable disease, environmental health, and chronic disease. Today, CDC is at a disadvantage because they do not have direct access to decision-makers in Washington. He urged CDC to look out for itself, because nobody else will look out for it.

Ms. Rosenbaum felt that despite an isolationist “stripe,” America’s greatest strength is that our DNA favors collective response to challenge. In her experience in Washington, political parties were not important; rather, there was a sense of doing things with collective response to challenges. The climate today reflects a social strain that has nothing to do with politics, but with an opposition to “the other” and to collective response to anything. Public health must use everything in their power to remind people that America is better when we respond collectively to a challenge. She wondered if CDC could find a symbol for what it does. She offered the example of a commercial that uses the Hoover Dam to illustrate that only people, working together, could accomplish such a feat. She believed that people are hungry to return to that part of the American DNA. CDC should capture that element of public health and its role as a community response to challenges.

Dr. Chu reflected on thought models and culture. If CDC wants to be a preeminent organization that pushes for the health of the world’s population, then he suggested that they keep that focus. Getting bogged down by other issues can invite dissention. The CDC priority to maximize health is the guiding principle. All of their work follows from their core purpose and framework, which helps with messaging, strategies, and tactics. The term “wellness” polls more favorably than “prevention.” If their goal is to maximize health, then they can focus their activities on what can be done quickly versus longer-term goals and issues, addressing social determinants of health and other questions in that context. Strategic planning must include well-thought-out strategies, and they can always return to their core purpose and high-level framework.

Dr. Palacio reflected on the political climate and the concept of public trust. Much of the public health enterprise relates to public trust, not only in engagement with the public, but also in building partnerships and leveraging and influencing without authority. We view actions through the lens of whether or not the person undertaking those actions is trusted. An action from a trusted source will not provoke anxiety, where the same action from an untrusted source will. Science and policy are easier to work with than the concept of how to become a truly trusted enterprise, especially in the current climate, where all government is not trusted. They should not ignore this challenge, because their ability to be effective rests on their ability to be trusted.



Ms. Drew Ivie described a new public health building that was recently opened in South Los Angeles. The opening ceremony included a healthy cooking demonstration in a new kitchen in the building. The community response was tremendous and positive. The community sensed that public health was interested in human beings and ready to partner with them to take charge of their lives. She was glad that healthy eating was a focus of CDC.

Dr. Greenberg suggested that CDC consider having a stronger presence in Washington. He envisioned a building with the CDC logo on it, with 250 full-time employees who are focused on collaborations with other domestic and international partners. CDC employees live and work all over the country and the world, but most of the federal budget decisions are made in Washington, DC. He advised that some of the CDC leadership populate this office. Not only will they have more frequent contact with policymakers, but also with partners such as HRSA and the National Institutes of Health (NIH). If members of CDC's leadership become part of the fabric of Washington, then they can raise the profile of public health.

Dr. Sanchez said that trustworthiness is a competency. He suggested that effort be made to develop that competency at the local, state, and federal level. "Health in all policies" has been an important mantra that should extend beyond government agencies. More work can be done in the private sector. He offered a schematic with circles for health, education, and economic development and wealth accumulation. These three circles meet, and CDC has been working in this "sweet spot" to engage people. Engaging the corporate sector in this "sweet spot" is essential. RWJ has funded summits around the country to see how corporate investments have health, education, and economic development impacts. The corporate sector should think differently about the work that CDC does and the value that CDC brings. Elected officials should be part of this conversation as well.

Ms. Rosenbaum added the topic of community benefit from changes in Internal Revenue Service (IRS) policies for hospitals. Hospitals can be the most powerful economic engines in their communities. Their world of community benefit tends to look inward, but the extent to which they see collective efforts to improve the health of their communities will reach powerful and influential people.

Dr. Bal referred to Dr. Greenberg's suggestion that CDC have a physical presence in Washington, agreeing that CDC should have more influence there. He noted the cache associated with CDC's rich history and pedigree. He raised the example of the National Cancer Institute (NCI), which is well-connected and has influence. Additionally, NIH is connected and fights for its budgets.



Dr. Farley commented on the public health workforce issue. He recalled his experience with academics, where undergraduate programs in public health are attracting “the best and brightest” young people. He encouraged thinking about how to get students with Bachelor’s Degrees in public health into the health departments.

Dr. Greenberg said that such discussions with the American Medical Association (AMA), the American Public Health Association (APHA), and academic institutions are occurring in Washington, DC. If CDC had a stronger presence in Washington, then they would be part of the connections and synergies there.

Dr. Sanchez observed that while the public health workforce may be siphoned elsewhere, such as the insurance industry, there are opportunities to use the notion of population health in places where it has not been before, such as Medicaid or hospitals. It is easier to talk about population health when people have a background in the language. Policies could be crafted in that language, raising the idea of population health and health status.

Dr. Frieden appreciated the conversation and agreed that their fundamental job is to maximize health. Staying at that level for as long as possible is important. They also have to “do a lot more with a lot less” and think about new ways to do business. They are in the midst of a large realignment. He pointed out that CDC has about 50 staff in Washington, DC in various offices. The National Institute for Occupational Safety and Health (NIOSH) has a Washington office. He agreed that commuting from Atlanta to Washington as frequently as he does is exhausting, but he is still not there enough to be part of the lifestyle.

Dr. Greenberg encouraged CDC to think strategically about which of its programs should be in Washington. Clearly, the legacy of CDC is in Atlanta and CDC will remain in Atlanta. But, the agency has become global, and many organizations have different headquarters in different cities.

Dr. Frieden asked the ACD to discuss the process of the committee. They generally meet twice a year, sometimes once by phone and once in person. He asked for their thoughts about their next meeting and how to make optimal use of their time. He said that they should continue to communicate and provide guidance between meetings, through the workgroups and other means.

### **Public Comment**

At 2:23 p.m., Dr. Sanchez invited public comment to the ACD. Hearing none, he continued with the agenda.

### **Closing Comments**

Dr. Sanchez thanked the ACD and CDC staff for contributing to the meeting. He reviewed the meeting and commented on its productivity. Four ACD members volunteered to work with CDC on communications issues and perhaps to populate





a Communications Workgroup. The Health Disparities Subcommittee met the day before, and the Policy Workgroup has been active as well. Updates from these workgroups will be included in the next ACD agenda. Ms. Rosenbaum noted that Dr. Isham expressed interest in joining the Policy Workgroup.

**Discussion Points:**

Dr. Greenberg commended CDC leadership for their presence at the meeting, which lends importance to the ACD meetings. He further commended the structure of the workgroups, which align with CDC's top priorities. The ACD agenda should include workgroup feedback, but perhaps in the future could include workgroup reports for half of the day, and devote the other half of the day to cutting-edge, important issues on which CDC needs feedback.

Dr. Chu commented that there is great value in the ACD meeting in person. He felt that their workgroup structure was effective. He suggested that they receive summaries of major findings and issues from the workgroups and CDC in advance, so that their discussions could be richer and productive.

Mr. Climan agreed that in-person meetings were preferable. He appreciated the framework of CDC's presentations at the meetings, which are framed in science and policy. He added that he would appreciate education on research and initiatives. There should be more research into what public health and personal health mean, and what CDC means. Contributions from external resources could be helpful as well in figuring out how to message for the 21<sup>st</sup> Century.

Dr. Henning added that meeting in person is preferable, and she approved of the idea of receiving updates in advance to prepare for the meetings. She asked that materials be provided two weeks in advance of the meeting to give them ample time to review it. While the workgroup reports are interesting, the open conversations are more fruitful, and she hoped that they would have plenty of opportunity for those discussions.

Dr. Bal said that ACD members can communicate with CDC and each other via email, but that communication pales in significance to the in-person interaction. He suggested a future retreat during which CDC could carve out time to evaluate the winnable battles.

Dr. Sanchez said that they may not have time to discuss all of their ideas at the meeting, but they should write down their good ideas and share them with Dr. Frieden and CDC. He suggested that they have a conversation the night before the ACD meeting as well, in a less formal setting. (Note: A FACA Committee can gather the night before for *social purposes only* but may not discuss any committee matters; those matters can only be discussed in the scheduled public meeting.)

Dr. Fleming agreed with meeting in person. An advisory committee works best when it advises on things that CDC needs advice on. He suggested that CDC select the issues on which the ACD can provide value-add to their thinking and help the committee focus so that they can provide what CDC needs.

Dr. Frieden said that the five priorities are the way he frames his thinking about the agency. OSELS is a new unit, and they have identified large gaps in bioinformatics and other areas. ACD identified opportunities in healthcare surveillance and the changing ways to get surveillance data. The STLT Workgroup has provided ways CDC can be more effective with state and local entities, and the ACD has provided advice on how CDC can be more effective as a whole. He asked about the timing of the meeting. The ACD indicated that ending at approximately 3:00 p.m. was convenient.

Ms. Rosenbaum said that it would not be difficult to have a “pre-meeting” the night before the ACD meeting as Dr. Sanchez suggested. Some workgroups meet the day before the ACD meeting, but they could convene in the late afternoon, or have a less formal dinner. (Note: A FACA Committee can gather the night before for *social purposes only* but may not discuss any committee matters; those matters can only be discussed in the scheduled public meeting.)

Dr. Richardson said that there was value for the workgroups to meet in person, and she hoped that the ACD agenda would not conflict with those meetings.

Dr. Greenberg did not think that the agenda was long enough to merit an additional meeting day.

Dr. Richardson said that as a new member, she enjoyed the informal dinner the night before and the chance to get to know the ACD members.

Dr. Ileana Arias said that this ACD meeting had been one of the best. ACD gave CDC many issues to think about. She asked ACD members to inform CDC if there were ways that the meeting could be made easier for them.

Dr. Rima Khabbaz agreed and noted that the previous day’s discussion in the GWG had been helpful. There is a new framework for infectious diseases, which she said she would forward to the ACD.

Dr. Robin Ikeda added that given the richness of the GWG discussion on the day before, she would learn a great deal from sitting in on other workgroup meetings.

Dr. Judy Monroe thanked Dr. Fleming, Dr. Farley, and Dr. Bal for their work on the STLT Workgroup, which was helping to advance the work of OSTLTS.



## Advisory Committee to the Director: Record of the October 27, 2011 Meeting

Mr. Andrew Rein commented that in the last six months, CDC has accelerated their presence and activity in Washington. They still have a long way to go, and he looked forward to ACD's additional comments on policy and partnerships.

Dr. Isham expressed that he would appreciate more supporting documentation, especially on the topics on which the ACD votes.

Dr. Sanchez asked whether ACD members were successful in retrieving the online documents. The ACD indicated that they were. Dr. Sanchez thanked Carmen Villar and Gayle Hickman, as well as the ACD.

Dr. Frieden thanked Ms. Villar, Ms. Hickman, and the other CDC staff who make the ACD meetings go smoothly. He said he looked forward to hearing on-going input from the ACD.

The meeting adjourned at 2:45 p.m.



**Certification**

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 27, 2011, meeting of the Advisory Committee to the Director, CDC are accurate and complete.

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Date

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Eduardo J. Sanchez, MD, MPH, FAAFP  
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

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

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

**Sanford R. Climan, MBA, MS**

President  
Entertainment Media Ventures, Inc.

**Sylvia Drew Ivie, JD (via telephone)**

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

**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, State, Tribal, Local and Territorial Workgroup

**Lynn R. Goldman, MD, 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, Global Workgroup

**Kelly J. Henning, MD**

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





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

Chief Health Officer  
HealthPartners Incorporated

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

Senior Vice President, Healthy Communities  
The California Endowment

**Jonathan (Jack) T. Lord, MD**

Chief Innovation Officer and Professor of Pathology  
Miller School of Medicine, University of Miami

**Herminia Palacio, MD, MPH**

Executive Director  
Harris County Public Health and Environmental Services

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

Professor of Emergency Medicine and of Health Evidence and Policy  
Mount Sinai School of Medicine

**Sara Rosenbaum, JD**

Harold and Jane Hirsh Professor and Founding Chair of the Department of Health Policy  
George Washington University School of Public Health and Health Services

**Eduardo J. Sanchez, MD, MPH, FAAFP**

Vice President and Chief Medical Officer  
Blue Cross and Blue Shield of Texas  
Chair, Advisory Committee to the Director

**ACD Members Absent:**

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

Fall 2011 Joan H. Tisch Distinguished Fellow in Public Health  
Hunter College of the City University, New York

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

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

**Suzanne Frances Delbanco, PhD, MPH**

Executive Director  
Catalyst for Payment Reform



**Mary Kelly**

Executive Vice President  
Merchandising and Category Management  
Shoppers Drug Mart

**CDC Staff Attending:**

**Ileana Arias, PhD**

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

**Drue Barrett, PhD**

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

**Ursula Bauer, PhD, MPH**

Director  
National Center for Chronic Disease Prevention and Health Promotion

**Beth Bell, MD, MPH**

Director  
National Center for Emerging and Zoonotic Infectious Diseases

**Colleen Boyle, PhD, MS Hyg**

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

**Janet Collins, PhD**

Associate Director for Program  
Office of the Director

**Katherine Lyon Daniel, BA, PhD**

Acting Associate Director for Communication  
Acting Designated Federal Officer, Communications Workgroup



**Kevin DeCock, MD, FRCP (UK), DTM&H**

Director, Center for Global Health  
Designated Federal Officer, Global Workgroup

**Linda Degutis, DrPH, MSN**

Director  
National Center for Injury Prevention and Control

**Thomas R. Frieden, MD, MPH**

Director, CDC  
Administrator, ATSDR

**Gayle J. Hickman**

Management Specialist, ACD  
Logistics Specialist, Advance Team  
Office of the Chief of Staff  
Office of the Director

**Gregory Holzman, MD, MPH**

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

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

Director  
Office of Noncommunicable Diseases, Injury and Environmental Health

**Rima Khabbaz, MD**

Director for Infectious Diseases

**Ali Khan, MD, MPH, ASG/RADM (Ret.), USPHS**

Director  
Office of Public Health Preparedness and Response

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

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

**Leonard Ortmann, PhD**

Public Health Ethicist  
Office of the Associate Director for Science

**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

**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

**General Public:**

**Kendra Cox**

Writer/Editor, Senior Technical Writing Lead

Cambridge Communications

**Verla Neslund, JD**

Vice President for Programs

CDC Foundation

**Charles Stokes**

President and CEO

CDC Foundation

**Chloe Knight Tonney**

Vice President for Advancement

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
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health (CDC)
CHIP	Children's Health Insurance Program
CIO	Centers, Institutes, and Offices
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare and Medicaid Services
CR	Continuing Resolution
CTG	Community Transformation Grant
DC	District of Columbia
DFO	Designated Federal Official
DUI	Driving Under the Influence
FDA	Food and Drug Administration
FETP	Field Epidemiology Training Program
FOA	Funding Opportunity Announcement
FY	Fiscal Year
GHI	Global Health Initiative
GWG	Global Work Group
HHS	(Department of) Health and Human Services
HPTN	Health Prevention Trials Network
HRSA	Health Resources and Services Administration
IRS	Internal Revenue Service
ISO	International Organization for Standardization
IT	Information Technology
MMWR	<i>Morbidity and Mortality Weekly Report</i>
MOH	Ministry of Health
MSM	Men Who have Sex with Men
NBAS	National Biosurveillance Advisory Subcommittee
NCD	Non-Communicable Disease
NCI	National Cancer Institute
NCPP	National Commission on Prevention Priorities
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
OD	Office of the Director
OMB	Office of Management and Budget
OSELS	Office of Surveillance, Epidemiology, and Laboratory Services
OSTLTS	Office for State, Tribal, Local and Territorial Support
PDMP	Prescription Drug Monitoring Program
PEPFAR	President's Emergency Plan for AIDS Relief
PGO	Procurement and Grants Office
PHAP	Public Health Associates Program
RFP	Request for Proposal

## Advisory Committee to the Director: Record of the October 27, 2011 Meeting

RWJ	Robert Wood Johnson
STD	Sexually Transmitted Disease
STLT	State, Tribal, Local, and Territorial (Workgroup)
US	United States
USDA	United States Department of Agriculture
USPSTF	United States Preventive Services Task Force
VFC	Vaccines For Children
WHO	World Health Organization
WIC	Women, Infants, and Children





SUMMARY OF THE INAUGURAL  
MEETING OF THE  
Global Work Group (GWG)  
Advisory Committee to the Director  
(ACD)  
Centers for Disease Control and  
Prevention (CDC)

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**Roybal Campus, Building 21**

**9 AM – 3 PM**

**October 27, 2010**

**Alan E Greenberg, GWG Chair**

**Kevin M DeCock, CGH Director and GWG DFO**

**Respectfully Submitted: November 23, 2010**

## **I. Development of the Global Work Group**

In spring 2010, Dr Thomas Frieden, CDC Director, established the Global Work Group (GWG) of the Advisory Committee to the Director (ACD) of CDC. The goal of the GWG is to provide guidance to the newly formed CDC Center for Global Health (CGH), and to make pertinent recommendations to the ACD. Dr Alan Greenberg, an ACD member, was asked to Chair the GWG, and Dr Kevin DeCock, CGH Director, was asked to serve as the Designated Federal Official (DFO) for the GWG.

During initial discussions, three initial focus areas were identified for consideration by the GWG: 1) Strategy and Structure; 2) Science and Program; and 3) External Relations. At the spring 2010 ACD meeting, six ACD members volunteered to serve on the GWG. In addition, six external experts, three international representatives, and three designated federal officials from the CGH were invited to serve on the GWG.

The inaugural GWG meeting was convened on the CDC Roybal campus in Atlanta on October 27, 2010, the day prior to the fall 2010 ACD meeting. This date was selected to facilitate both the travel of the ACD members, and the report back to the ACD on the following day.

## **II. Inaugural GWG Meeting Participants**

### **GWG Members Attending**

David Fleming	Seattle-King County	ACD Member
Alan Greenberg	George Washington U	ACD Member
Kelly Henning	Bloomberg Foundation	ACD Member
Mary Kelly	Shoppers Drug Mart	ACD Member
Mickey Chopra	UNICEF	External Expert

Walter Dowdle	Task Force for Global Health	External Expert
Helene Gayle	CARE	External Expert
Joseph McCormick	U of Texas SPH	External Expert
Andrew Weber	DOD	External Expert
Willis Akhwale	MOH, Kenya	International Representative
Kevin DeCock	CGH Director	Designated Federal Official
Patricia Simone	CGH Principal Dep Director	Designated Federal Official
Donald Shriber	CGH Dep Director Policy & Communications	Designated Federal Official

**GWG Members Unable to Attend**

John Seffrin	Am Cancer Society	ACD Member
Louis Sullivan	Morehouse U	ACD Member
Ruth Levine	USAID	External Expert
Richard Kamwi	MOH, Namibia	Int'l Representative
Yu Wang	CDC China	Int'l Representative

**Other Participating CGH and CDC Staff**

Debbi Birx	Division Director, DGHA/CGH
Sandra Bonzo	Principal Advisor, ONDIEH/CDC
David Bull	Health Scientist, DGDDER/CGH
Joanne Cono	Special Advisor for Science Integration, OID/CDC
Mark Eberhard	Division Director, DPDM/CGH
Nick Farrell	Acting Dep. Director for Mgt. & Overseas Operations, OD/CGH
Jan Hiland	Workforce Management Officer, OD/CGH
Gena Hill	Special Advisor to the Director, OD/CGH
Libby Howze	Branch Chief, DPHSWD/CGH
Bereneice Madison	Acting Associate Director for Lab Science, OD/CGH
Eric Mast	Associate Director for Science, GID/NCIRD
John Ridderhof	Associate Director for Lab Science, OD/NCEZID
Robert Spengler	Acting Associate Director for Science, OD/CGH
Marsha Vanderford	Associate Director for Communications, OD/CGH

### **III. Meeting Format**

The meeting was called to order at 9 AM. Following introductions, power point presentations were given for each of the three GWG focus areas by the three CGH DFOs: Dr DeCock on Strategy and Structure; Dr Simone on Science and Program; and Dr Shriber on External Relations.

Each of these presentations was followed by vigorous GWG discussion. CGH senior staff members were present and participated in the discussion. Detailed minutes were recorded during the meeting.

In the final hour, the GWG summarized their reflections and recommendations, and the meeting was adjourned at 3 PM. On the following day, the GWG Chair presented a summary of the GWG discussions to the ACD.

### **IV. Highlights of CGH Presentations**

Complete summaries of the presentations of the three CGH representatives (Drs DeCock, Simone and Shriber) are in the minutes. This section will briefly summarize some of the pertinent highlights of these presentations

#### **Strategy and Structure**

Dr DeCock presented an overview of the CGH. He described the growth of CDC's activities in global health over the past 50 years, and especially during the past 5-7 years in response to major Presidential initiatives (PEPFAR and PMI). CDC has developed an extensive staff presence in numerous countries around the world. With the recent formation of the CGH through the merging of four large CDC Divisions, most global field staff and funding are now concentrated in the CGH; however, there is also extensive involvement of CDC staff in global health activities throughout the organization and in other Centers. The CGH has established partnerships with USG agencies, with bilateral and multilateral organizations, and with non-governmental organizations and Foundations.

Dr DeCock noted the increasing global impact of non-communicable diseases (NCDs) and injuries, adding to the existing burden of infectious diseases. The steady decrease in overall mortality among children has been accompanied by a steady increase in premature adult mortality due to both infectious and non-communicable diseases. The CDC Director has defined five “winnable battles” in global health, including immunization initiatives including polio eradication, mother-to-child HIV transmission and congenital syphilis, lymphatic filariasis, tobacco control and motor vehicle injury prevention.

The CGH has defined three important themes of its strategic focus, namely “one CDC”, “global health is global”, and “taking a seat at the high table”. “One CDC” refers to having a single CDC voice for global health both at headquarters and in partner countries. “Global health is global” refers to the importance of focusing CGH resources and staff in partner countries where public health programs are needed and where impact can be demonstrated. “Taking a seat at the high table” means that CDC should be included in key strategic discussions about major global health issues along with other prominent USG agencies, multilateral organizations and Foundations.

### **Science and Program**

Dr Simone presented an overview of the major current CGH activities, which include the Global AIDS Program, Malaria, Neglected Tropical Diseases, Global Disease Detection, International Emergency and Refugee Health, Field Epidemiology and Laboratory Training Programs, Sustainable Management Development Program, and the Global Immunization Program (scheduled to join the CGH in the coming year).

Dr Simone also noted that there were a host of other CDC activities in global health occurring throughout the organization. These include programs in tuberculosis, malnutrition, safe water, maternal and child health, occupational health, tobacco prevention, toxic substances, and injuries and non-communicable diseases.

### **Issues in CGH Environment**

Dr Shriber briefed the GWG on major issues that affect the CGH and the environment in which it operates. These include that the CGH receives funding largely from defined programs and has limited discretionary resources; the Presidential Global Health Initiative, with active collaboration between the leadership of CDC, USAID and the Office



of the Global AIDS Coordinator; unprecedented yet leveling investments in global health; a strong priority of the USG to move towards “country ownership” of bilateral programs, which is compelling CDC to re-think how it works in partner countries; and the extensive and growing engagement of other USG agencies, research institutions and foundations in global health – whose participation, though welcome, is contributing to the complexity of the global health environment.

## **V. Major Themes of GWG Discussion**

There were numerous comments, questions and suggestions that arose during the discussion sessions of the GWG meeting; these are captured in detail in the minutes. In this section, four major “themes” that emerged during these discussions are summarized.

### **The CGH is Impressive and is off to a Strong Start**

**The GWG was extremely impressed by the progress the CGH has already made in integrating four large Divisions into a single organizational entity.** This process, according to the respective Division Directors, appears to have unfolded rapidly and relatively smoothly. The CGH has the important public health responsibility of overseeing the highly visible programs enumerated above. The large CGH staff has great depth and breadth in technical and programmatic expertise. The leadership of Center and its Divisions are highly capable and committed to global health and CDC – energized by the great opportunity of establishing a new and important Center, yet cognizant of the magnitude of the challenges that lie ahead. Lastly, the GWG recognized the extraordinary CGH asset of having so many “boots on the ground”, i.e. CDC staff stationed around the world, both in partner countries and in multilateral agencies

### **Envisioning the Potential of the CGH**

**The CGH has an historic opportunity to play a transformative role in global public health, to envision and do something that has not been done previously.** To realize its potential, though, the CGH needs to become “more than the sum of its parts” by defining and then demonstrating the value the Center can add above and beyond the capacity of the Divisions it inherited from other CDC Centers and the former

Coordinating Office for Global Health. It is important for the CGH to identify several “quick wins” in the next several years to demonstrate how the benefit of establishing the Center was worth the cost of considerable organizational change.

Several potential strategic directions were suggested for consideration by the CGH. First, the domestic legacy of CDC was to contribute to the successful building of the epidemiologic and laboratory capacity and infrastructure of State and Local Health Departments to the point of public health self-sufficiency. The CGH could define its mission as translating this legacy to the global setting, working to develop and support the public health capacity and infrastructure of Ministries of Health around the world. The CGH could build on its existing vertical programs in partner countries and broaden them into horizontal public health platforms.

Additionally, there is an opportunity for the CGH to define and develop a prevention agenda for non-communicable diseases and injuries in the global setting. Given the evolving importance of NCDs and injuries, and the current focus and funding of most global health organizations (including CDC) on combating infectious diseases, the CGH could take the lead of defining an agenda in this arena and advocating for resources to support related programs. This approach would enable the CGH to get “ahead of the curve” and establish itself as a global leader in this arena.

### **Pressing Need for a CGH Strategic Plan**

**Given the above considerations, the GWG felt that there is a pressing need for a comprehensive strategic planning process so that the CGH can begin to define in writing its future strategic directions.** The current CGH mission statement is lengthy and includes a series of phrases describing the responsibilities of the Center; there is a need to develop a new guiding CGH mission statement that is consistent with the overall CDC mission and that is focused on the global populations that the CGH serves.

A central element of the strategic planning process needs to be an emphasis on protecting the core CGH programs (PEPFAR, Malaria, NTD and GHI), while defining and building a longer-term vision for global health. The GWG believes that it is important for the CGH Strategic Plan to develop Goals for non-communicable disease and injury prevention that could serve as the basis for seeking new resources. Numerous voices should be included in the strategic planning process, in addition to key CGH staff; these

include globally-active staff from other CDC Centers, and representatives of other USG agencies, Foundations, and other multilateral and Ministry of Health partners.

It is envisioned that the development of a CGH strategic plan would be accompanied by the re-drawing of the organizational structure. The current organizational chart includes the CGH leadership and the four CGH Divisions; a future organizational chart should include the country programs to emphasize visually the CGH theme of “global health is global”.

### **Importance of Partnerships and Developing CDC’s Strategic Voice**

**The importance to the new CGH of public health partnerships and developing its strategic voice in the global public health arena were recurring themes that emerged during the GWG meeting.** It will be critical for the CGH to develop partnerships internally at CDC with other Centers to demonstrate how the CGH will support and enhance their global work; the CGH has already developed a discrete office to focus on this issue.

Externally, while the CDC is recognized globally as having a strong and trusted technical voice, the creation of the CGH provides an opportunity for CDC to develop its strategic advocacy voice as well - at country-level, with other USG agencies, and with the global partners that are already “at the high table”. The GWG suggested that the CGH consider developing a specific agenda and a discrete CGH organizational unit to focus specifically on partnerships; since CDC cannot “do it all”, it must engage partners to increase their awareness of CDC’s considerable strengths and agenda in global health. These issues may be critical to the long-term survival of the CGH, as ensuring that CDC has a “seat at the high table” that will enable it to help define the directions of future global health funding in a post-PEPFAR era.

Lastly, there was felt to be a clear need for the leaders of the CGH to actively and strategically engage with their USAID counterparts to define the complementary strengths of the two organizations, and to further integrate the global health agenda of CDC with the development agenda of USAID. The Global Health Initiative has already built a strong base for these discussions at the highest level of the organizations, and several GWG members offered to help facilitate these discussions if requested.

## **VI. Summary and Next Steps**

In summary, the inaugural meeting of the GWG was conducted successfully, and the key themes outlined above were presented to the ACD the following day.

The GWG will now invite GWG members and CGH leadership to make suggestions about what other organizations or persons might be represented at the next GWG meeting. As was the case for the initial members, these suggestions will be reviewed by the CGH and subsequently by the CDC OD. In addition, for several critical organizations represented on the GWG, the GWG will work to ensure that if specific invitees are unable to attend, that an alternative representative be invited from these organizations.

It will be critical to ensure increased global representation at future GWG meetings. The voice of Dr Akhwale was essential to represent the perspectives of country partners, but would be greatly strengthened by the presence of several additional GWG international representatives. The GWG recognizes the travel costs associated with these meetings, as well as the challenges of ensuring that the senior international representatives have sufficient lead time to secure approval for their travel from their governments. Accordingly, the GWG will work closely with the CGH leadership to send invitations out for the next meeting in the near future, and to identify alternative international representatives should the invitees be unable to attend.

The next GWG meeting will be held on April 27, 2011, on the day prior to the spring 2011 ACD meeting. Although it was initially envisioned that the GWG would meet in-person only once annually, the consensus of the GWG was that it would initially meet twice annually given the myriad of developmental issues that the CGH is facing. The GWG leadership is grateful for the additional time commitment that the GWG members have proposed.

Lastly, the GWG members look forward to continuing a dialogue with the CGH leadership to determine if there are ways in which its members can be helpful in between the biannual meetings. For example, GWG members could facilitate interactions with partner organizations, or help in the review of the strategic plan.

SUMMARY OF THE SECOND MEETING  
OF THE  
Global Work Group (GWG)

Advisory Committee to the Director  
(ACD)

Centers for Disease Control and  
Prevention (CDC)

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**Roybal Campus, Building 19**

**10 AM – 4 PM**

**April 27, 2011**

**Alan E Greenberg, GWG Chair**

**Kevin M De Cock, CGH Director and GWG DFO**

**June 15, 2011**

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## **I. Global Work Group (GWG) Background and Timeline**

Spring 2010: Dr Thomas Frieden, CDC Director, establishes the GWG of the Advisory Committee to the Director (ACD) of CDC to provide guidance and pertinent recommendations to the ACD regarding the newly formed CDC Center for Global Health (CGH). Three focus areas were identified for the GWG: Strategy and Structure, Science and Program and External Relations.

October 27, 2010: Inaugural GWG meeting held at CDC.

October 28, 2010: Summary of the GWG meeting presented at ACD meeting.

April 27, 2011: Second GWG meeting held at CDC. This meeting was initially envisioned as a conference call, but due to the recent formation of both the CGH and the GWG, it was decided that the second GWG meeting would be in person.

April 28, 2011: During ACD conference call, written summary and minutes from first GWG meeting submitted to the ACD; ACD informed that the second GWG meeting had just been held; and time requested for a GWG update at the fall ACD meeting.

October 26, 2011: Third GWG meeting at CDC (scheduled).

October 27, 2011: GWG update to the ACD (requested).

## **II. Second GWG Meeting Participants**

### **GWG Members Attending**

Alan Greenberg (Chair), Kevin De Cock (DFO), Walter Dowdle, David Fleming, Joseph McCormick, Yu Wang, Andrew Weber and Pattie Simone

### **GWG Members Unable to Attend**

Willis Akhwale, David Brandling-Bennett, Mickey Chopra, Kelly Henning, Richard Kamwi, Mary Kelly, Ruth Levine, John Seffrin and Donald Shriber

### **Center/Office Update Presenters**

Mary Chu OSELS, John Douglas NCHHSTP, Henry Falk ONDIEH, Arlene Greenspan NCIPC, Rana Hajjeh NCIRD, Tom Hearn NCEZID, Maria Lioce-Mata NIOSH, Sam Posner NCCDPHP, and Alik Weakland NCBDDD

### **Other Participating CGH and CDC Staff**

Sonia Angell CGH, Ron Ballard CGH, Peter Bloland CGH, Coleen Boyle NCBDDD, Steve Cochi NCIRD, Joanne Cono OID, Kendra Cox (contract writer-editor), Scott Dowell CGH, Mark Eberhard CGH, Brandi Geiger (Deloitte & Touche contractor), Jan Hiland CGH, Nathan Huebner CGH, Rima Khabbaz OID, William Levine CGH, Nancy Nay CGH, Lisa Rotz NCEZID, Can Rutz CGH, Larry Slutsker CGH, Nicole Smith CGH, Brian Sodl (Deloitte & Touche contractor) and Robert Spengler CGH

## **III. Meeting Format**

The meeting was called to order at 10 AM. Following introductions, six power point presentations were made on the Inaugural GWG Meeting, CGH Update, Non-Communicable Diseases, Policy, Polio Eradication and Haiti (see highlights below). Each presentation was followed by an interactive GWG discussion. Brief 3-minute presentations were then given on the global health activities of nine other CDC Centers and Offices. Lastly, final comments were made by all GWG members. The meeting was adjourned at 4 PM.

## **IV. Highlights of Presentations**

Complete summaries of the presentations and the discussion points can be found in the minutes of this meeting. This section will briefly summarize some of the pertinent highlights of these presentations

### **Inaugural GWG Meeting**

Dr Greenberg presented a summary of the four Discussion Themes that emerged during the first GWG meeting.

1. The CGH is Impressive and is off to a Strong Start: The GWG was impressed by the formation of the CGH itself; the capable leadership of the CGH; the magnitude of its existing global programs; the considerable asset of large numbers of CDC staff stationed globally (“boots on the ground”); and the smooth integration of four large Divisions into a new CDC Center.
2. Envisioning the Potential of the CGH: The GWG felt that the CGH has an historic opportunity to play a transformative role in global public health; to envision and do something that has not been done previously; to become “more than the sum of its parts”. Specifically, the CGH could consider translating the domestic legacy of CDC - building the epidemiologic and laboratory capacity and infrastructure of State and Local Health Departments - to the global setting - by developing and supporting public health capacity and infrastructure of Ministries of Health. The CGH could build on existing vertical programs in partner countries and broaden them into horizontal public health platforms; and define a prevention agenda for non-communicable diseases (NCD) and injury prevention in the global setting.
3. Pressing Need for a CGH Strategic Plan: The GWG felt that there was a pressing need for the CGH to initiate a comprehensive strategic planning process. This plan should protect the core CGH programs while concurrently defining and building a longer-term vision for global health that included NCD and injury prevention. It was suggested that numerous voices be included in the strategic planning process including the CGH, other CDC Centers, other USG agencies, Foundations, and multilateral and Ministry of Health partners.
4. Importance of Partnerships and Developing CDC’s Strategic Voice: The GWG felt it was critical for the CGH to support and enhance the global work of other CDC Centers; to develop CDC’s strategic advocacy voice in global health; to consider developing a discrete CGH organizational unit to focus specifically on partnerships; and to continue to engage strategically with USAID.

### **Center for Global Health Update**

Dr DeCock provided an overview of CGH progress and activities in the past six months. All CGH senior leadership positions in the Office of the Director have now been filled by highly qualified staff. The CGH estimates its FY 2010 budget to be \$2.2B, of which 87% is for Global AIDS. There are 387 overseas positions, of which 75% are filled; and 44 CGH staff detailed to international organizations. There are currently 40 “presence countries” in which CDC has full-time staff, and an additional 18 “non-presence

countries” in which CDC has activities without full-time staff. Under the guiding principal of “one CDC”, the CGH developed and released in January 2011 a “Governance Document for Country Offices and Global Operations”, which designates a single Country Director for all presence countries; a Country Representative for all non-presence countries; and establishes a defined support structure (Country Coordinating Teams) in Atlanta for each country.

The CGH has made considerable progress in identifying the spectrum of global health activities in other CDC Centers, and by beginning to define its role in “leading and coordinating” global health activities across the agency. Key 2010 accomplishments were then provided for: the Field Epidemiology Training Program (FETP) for global workforce and capacity development; the Global Disease Detection Program; the launch of the African Society for Laboratory Medicine; the planned integration of the Global Immunization Program into the CGH this fall; and malaria and neglected tropical diseases. Updates on the five global “winnable battles” outlined by the CDC Director were then presented, namely on the reduction of mother-to-child HIV and syphilis transmission, global immunizations, lymphatic filariasis, tobacco control and motor vehicle injury prevention.

CGH has also worked on setting communications priorities on increasing the focus on CDC’s global health vision, awareness of the value of CDC’s global health work, and visibility of CDC’s global health programs. A suggestion was made about CGH communicating its message to reach people more personally with things that make a difference in their lives in order to get public health more visibility at the grass roots level.

Lastly, the CGH has engaged Deloitte & Touche to facilitate the development of the CDC global health strategy. Draft vision, mission, guiding principals, focus areas, and a timeline of April-June 2011 for developing the plan were presented.

### **Non-Communicable Diseases (NCD) and Injury Prevention**

Dr Angell presented an update on NCD. The CGH budget for NCD is \$5M. Expertise on NCD in the global setting is located throughout CDC, and a strategic planning meeting was held in February 2011 to begin to formulate a single organizational framework for NCD and injury prevention. The primary focus is on tobacco and motor vehicle injuries (“winnable battles”), with a secondary emphasis on cookstoves, folic acid fortification, and sodium reduction. It is envisioned that country level NCD capacity could be expanded through engaging current CDC global staff, strategically placing new staff to focus on NCD, and through the FETP. Countries with current CDC NCD resource

allocations include China, Columbia, Jordan, Tanzania and Thailand; with other activities ongoing in Africa, Asia and Latin America. There are upcoming opportunities for CDC to participate in NCD planning globally, including UN Summit Preparations in Mexico and Russia in March and April 2011, indicator development with WHO, and the UN Summit itself in September 2011.

## **Policy**

Dr Smith presented an update on CGH policy issues. She discussed recent changes in Congress, an increased USG emphasis on health security, and the CDC goal of avoiding budget reductions. The CDC budget for global health activities in FY 2011 has been relatively stable. The CGH website has been improved. There has been a significant policy focus on the Global Health Initiative (GHI) to improve collaboration with other USG agencies and other in country partners. The recently issued US Department of State Quadrennial Diplomacy Development Review (QDDR) describes current US government diplomacy and development objectives and has implications for global health planning.

## **Global Polio Eradication**

Dr Cochi summarized the extensive progress that has been made towards global polio eradication over the past 25 years, including the eradication of type 2 polio in 1999. The number of countries where polio was endemic has declined from 125 in 1988 to 4 in 2008. He described the 2010 outbreaks in Tajikistan and Congo; the re-established transmission areas in Sudan, Chad, Angola and DR Congo; and the immunization efforts in the two most important global reservoirs (India and Nigeria), as well as in the two other endemic countries (Pakistan and Afghanistan).

## **Haiti**

Dr Dowell summarized CDC's extensive activities in health system reconstruction in Haiti, a country with limited public health infrastructure. The CDC Global AIDS Program in Haiti is funded by PEPFAR, was established in 2002, and had 45 locally employed staff. Following the severe earthquake in Haiti in January 2010, numerous public health issues emerged. CDC responded by providing technical assistance to the Ministry of Health, and with the approval of Ambassador Goosby, building upon PEPFAR-funded infrastructure and staff. Disease surveillance systems were established, microbiologic capacity was developed, \$22M was received for public health reconstruction, and 383 CDC staff have been deployed to work on various disease surveillance and prevention activities. A cholera epidemic was identified in October 2010, with an additional \$54.8M

authorized. From October 2010 through March 2011, there have been 258,084 cholera cases and 136,946 hospitalizations

### **Updates from Other CDC Centers**

Brief 3-minute presentations were given by nine CDC Centers and Offices summarizing their global health activities; complete summaries of these presentations are in the minutes. There was a most impressive scope of activities presented, and the extensive expertise and involvement of numerous staff at CDC in global health was evident. Although it was challenging for the GWG to fully absorb all of these global health activities in a brief period of time, the GWG greatly appreciated the participation of other CDC Centers and Offices in the GWG meeting; was aware that the CGH is in the process of “getting its arms around” the full breadth of global activities at CDC; and would welcome more in-depth briefings about these activities at future meetings.

## **V. Progress and Discussion on Four Major GWG Themes**

In this section, CGH progress and GWG discussions are summarized for each of the four major GWG themes outlined above. A more detailed description of the discussion is contained in the minutes.

### **The CGH is Impressive and is off to a Strong Start**

**The CGH has continued to make considerable organizational strides towards establishing itself as a new and vibrant Center at CDC.** The four CGH Divisions are apparently functioning well in the new Center, and the Global Immunization Division is scheduled to join the Center in fall 2011. The CGH Office of the Director has been fully staffed, with specific staff designated to focus on NCD and policy. The CGH has made important strides to quantify all fiscal and budgetary resources that it is responsible for both in Atlanta and globally, and has made progress in identifying global health activities located in other CDC Centers. The development and implementation of the *Governance Document for Country Offices and Global Operations* represents an important step forward in establishing clear in-country leadership for CDC programs, and in providing and coordinating support for these programs from Atlanta.



The CGH seems to be striking an effective balance between centralizing and de-centralizing global health activities at CDC – playing a needed central coordinating role, while actively engaging and supporting other CDC Centers. The creation of the CGH can raise the profile of global health at CDC, and can serve as the voice of CDC in multiple global settings and forums. The CGH can be conceptualized as having two primary and complementary responsibilities – interacting with countries and regions through the activities of the CGH and other CDC Centers working globally; and interacting with other international organizations to serve as the face of CDC on global health.

### **Envisioning the Potential of the CGH**

**Much of the GWG discussion focused on a central theme of the first meeting – that the CGH has an historic opportunity to play a transformative role in global public health - notably in building global public health infrastructure and developing a focus on non-communicable diseases and injury prevention. These issues are addressed in this section.**

#### *Building Public Health Infrastructure*

The issue of how the CDC domestic legacy of building capacity and infrastructure of State Health Departments could be translated to global setting was explored in more depth during this meeting. The GWG recognized that transformation is challenging, yet felt that the time frame of developing public health infrastructure globally will be measured in decades, and small investments now could have a huge impact long-term. This sentiment was encapsulated by the phrase “it takes a while to change the world”.

The CGH was encouraged not to allow the current challenging fiscal situation to lead to being under-ambitious. It was noted that CDC only received significant congressional funding for global programs in the past decade, and that the CGH could focus on creating opportunities for future funding so that it will be prepared when the fiscal crisis eases. The recent emphasis of the USG on health security and international health regulations present opportunities to further the global health agenda; CDC could capitalize on the Global Disease Detection Program, and emphasize how public health lessons learned globally can be applied domestically.

There were numerous suggestions for how CDC might approach the development of global public health infrastructure. There is an opportunity to capitalize on the considerable infrastructure built by the infusion of Global AIDS Program resources to build public health infrastructure in-country; this was clearly demonstrated in the CDC emergency response to the earthquake and cholera outbreak in Haiti and can be used as an example for other countries. The CGH could build on its existing vertical programs in partner countries and broaden them into horizontal public health platforms. There is also an opportunity to capitalize on CDC's domestic expertise in integrated biosurveillance for integrating information systems for multiple diseases globally.

The CGH could work to convert from an emergency response perspective to that of building public health capacity and infrastructure. In partnership with Ministries of Health, the CGH could prospectively formulate and define what it means to build public health infrastructure and to reconstruct health systems in the global setting, as well as defining what CDC's role is in these initiatives. CGH could define the critical elements required to build public health infrastructure, including training, surveillance, epidemiology, laboratory services, clean water, sanitation, etc.; with clear outcomes and goals established. In country, it will be important to assess which governmental sectors and Ministries could work with the health sector to build public health capacity and infrastructure. While developing public health capacity, it will be important to work closely in partnership with affected communities to inform the development and implementation of effective public health programs. Lastly, it will be critical to define measurable goals and outcomes in advance so that the success of the CGH can be monitored.

#### *Field Epidemiology Training Program (FETP)*

The FETP is a critical tool that CDC can use towards the greater goal of building global public health infrastructure. It is important to clearly communicate the role of FETP to academic partners in host countries, and there is a need for standardized guidelines and didactic materials for FETP training. Following FETP training, it is important to encourage the diffusion of trained epidemiologists into affected communities to maximize their ability to make impactful change. Lastly, a deliberate and formalized approach could be developed to encourage countries which are in the process of becoming economically independent to begin to share and then assume the costs of FETP training.

## *Non-Communicable Disease and Injury Prevention*

One of the central themes of the first GWG meeting was the opportunity for the CGH to define and develop a prevention agenda for non-communicable diseases and injury prevention in the global setting. With strong support and leadership from both the CDC and CGH Directors, the CGH appears to have made considerable progress in embracing these issues as priorities for its global activities: establishing a cross-Center CDC work group on NCDs to connect the considerable expertise that exists throughout CDC; creating a senior position in the CGH OD to coordinate and guide NCD and injury prevention activities - with the plan to create several other NCD positions in Atlanta and potentially globally; identifying a budget of \$5M for NCD; and working to increasingly integrate NCD training into the FETP.

The GWG reiterated that there remains a critical strategic opportunity to position CDC as a global leader in NCD by capitalizing on its considerable strengths in epidemiology, laboratory and training. Although the costs of building surveillance capacity for NCD and injury prevention can be relatively small, the potential public health gains can be considerable; a concrete example was provided of the initiation of motor vehicle accident surveillance in Karachi leading to improved traffic control measures, which in turn led to a reduction in accidents. The training of epidemiology and laboratory personnel in the US has traditionally focused on infectious diseases rather than NCD; there is an opportunity to learn from this experience and ensure that globally a workforce is trained (through the FETP and academic institutions) that is better prepared to confront NCD. It will also be important to integrate NCD and infectious disease research and programs globally as there are important interactions between them; examples of this were clinical interactions between tuberculosis and diabetes, and obesity and diabetes as risk factors for influenza. It was noted that NCD were not highlighted in the QDDR, thereby creating a strategic niche for CDC; and that NCD lend themselves to seeking partnerships for collaboration and potentially for funding with private foundations that focus on individual NCD.

### **Pressing Need for a CGH Strategic Plan**

**Since the first GWG meeting, the CGH has successfully initiated the process of developing a strategic plan.** A consulting firm, Deloitte & Touche, has been engaged to assist with the process of developing a global health strategy, and a draft strategic framework has already been written which includes a draft vision consistent with the overall CDC vision; a draft mission focused on strengthening public health capacity and improving global health; the guiding principles of a unified CDC approach and structure,

central role of demonstrating programmatic impact, and assuming a prominent role in shaping global health strategy; and four defined “focus areas” of health impact, health security, regional/country capacity, and organizational capacity. A time line for the development of the strategic plan has been established, with the anticipation that this process should be completed by summer 2011.

The GWG was impressed by this progress. The importance of ensuring that the plan would directly address the development of global public health capacity was emphasized. In addition, the suggestion that the plan should emphasize the inclusion of an approach to non-communicable diseases and injury prevention was reiterated. The CGH should strongly consider developing “horizontal” goals focused on broad global public health themes, rather than “vertical” goals focused on the major foci of the individual CGH Divisions; this approach could contribute to the further integration of the Divisions into the CGH under a common purpose, and could help to define broader and more long-term goals that are consistent with a CGH vision of the global health. The GWG continued to suggest that numerous voices from outside the CGH be included in the actual development (and not simply the review) of the plan; these could include other CDC Centers, USG agencies, foundations, multilateral and Ministry of Health partners. Lastly, the CGH requested that individual GWG members review and comment on the plan; GWG members seemed willing to do so, but requested that the CGH first work with the ACD and with MASO to ensure that this was permissible.

### **Importance of Partnerships and Developing CDC’s Strategic Voice**

**The importance of public health partnerships and developing CDC’s strategic voice in global public health was a major theme of the first GWG meeting.** In this section, the discussion about these issues in the second GWG meeting is summarized.

#### *Partnerships*

The importance of the CGH developing strong partnerships with other global health organizations was stressed at the first meeting. While the CGH appears to have made progress internally at CDC in establishing connectivity with other CDC Centers, there was less evidence of a strategic approach to developing and nurturing external partnerships. There is no organizational unit within CGH with a focus on external partnerships, although a new position has been created in the CGH to focus on this issue. Ongoing challenges of partnering with USAID were noted – an underlying concern

is that USAID views its development role as being very broad and by necessity encompassing health-related issues – thereby creating potential overlap between USAID and CDC activities in the US and in partner countries.

There is great potential for the CGH to establish partnerships with the private sector, and it was noted that these could be pursued through the CDC Foundation. Other CDC Centers indicated that there are existing domestic public–private partnerships that could be expanded upon globally, such as the CDC partnership with the Rotary Club on polio eradication. It was suggested that when developing partnerships with private foundations, CDC should first seek programmatic collaboration, and if successful could then seek co-funding of projects later on.

#### *Developing CDC's Strategic Voice*

The CGH is making important strides to understand the totality of global health activities throughout CDC; this presents an important opportunity to package and strategically communicate the extent of CDC's global health involvement through the CDC website, written materials, and presentations by CDC and CGH leadership at global health meetings. In addition, now that the CGH will soon be “whole” with the imminent integration of the Global Immunization Division, concrete examples of synergy that did not exist previously should be identified and developed - within the CGH, within CDC, within the USG, and with other global health organizations. The CGH should proactively track and communicate its accomplishments to demonstrate its added value at CDC.

The observation was made that CDC often appears to be more comfortable contributing to public health rather than leading it, and needs to learn how best to ensure its “seat at the high table” and influence global health policy without losing its “helpful” stature. A concrete plan for developing CDC's strategic leadership voice on global public health issues has not yet been articulated, and the CGH has not yet developed full “traction” on this issue. Updates on this issue at future GWG meetings would be welcomed.

## **VI. Process Issues and Next Steps**

GWG Membership: There seemed to be consensus that the GWG was reasonably sized and appropriately populated. However, attendance at this meeting by GWG members was suboptimal due to several late and unavoidable cancellations. The challenges of including international representation in this meeting due to travel issues continued, although very critically Dr Wang Yu was able to attend the meeting in person. The GWG requested that a commitment for attendance be requested politely from members, with alternatives sought for those who are unable to commit.

GWG Scheduling: It was agreed that the third meeting of the GWG would be held in Atlanta on October 26, 2011. This would resume the GWG schedule that was initially envisioned – in-person meetings each fall in Atlanta, and conference calls each spring – all on the day prior to the ACD meeting so that GWG updates can be provided immediately to the ACD. CGH should look into the capabilities of video conferencing for future GWG meetings that are scheduled as conference calls or to enable members to engage in meetings they cannot be physically present for.

Preparation for Future GWG Meetings: To the extent possible, the CGH should brief the GWG about ongoing global health activities in advance of GWG meetings through the electronic distribution of written briefing materials. The CGH should also identify key issues in which GWG discussion would be most valuable to CDC. In this manner, GWG meetings could be focused less on updates from CGH staff, and more on discussion of selected strategic issues.

### **GWG Requests for Clarification from CDC**

The GWG asked the CGH DFO to seek guidance from CDC on several issues.

1. Summaries and minutes from each GWG meeting are being submitted routinely to the ACD, and verbal updates to the ACD are being made by the GWG Chair as frequently as the schedule of the ACD allows. Do these summaries and minutes need to be formally approved by the ACD?

2. Senior CGH staff are active participants in GWG meetings and therefore have the opportunity to consider the input of GWG members in real time before the ACD has reviewed (and perhaps even approve of) the written summaries and minutes. This seems functional to GWG members, but the GWG would like to confirm that this is acceptable to CDC.

3. GWG members have expressed a willingness to be consulted by the CGH (either as a group or individually) on selected strategic issues between regularly scheduled GWG meetings. For example, the CGH could seek GWG review and comment of the CGH strategic plan. Are GWG members permitted to provide this type of input?

## **VII. Summary**

The second GWG meeting was conducted successfully. A brief verbal report of the second GWG meeting, as well as a written summary and minutes from the first GWG meeting, were presented to the ACD on their spring conference call the following day.

Updates on major CGH activities were presented by senior CGH leadership, and brief presentations were made by nine other CDC Centers summarizing their extensive global health activities. Each of the four major themes of the first meeting – successful launch of the CGH, transformative global public health opportunities, need for a CGH strategic plan, and developing partnerships and CDC's strategic global health voice - were discussed during the second meeting, with particular attention paid to the CGH potential roles in the development of public health infrastructure and non-communicable diseases.

The GWG will work to consolidate its membership, and looks forward to receiving guidance from CDC on the issues outlined above.