Minutes from the April 26, 2012

CDC Advisory Committee to the Director

Release Date
July / 2012

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Advisory Committee to the Director
Record of the April 26, 2012 Meeting

The Centers for Disease Control and Prevention (CDC) convened a meeting of its Advisory Committee to the Director (ACD) on April 26, 2012, at the Arlen Specter Headquarters and Emergency Operations Center in Atlanta, Georgia. The agenda included reports from the Global Workgroup (GWG); the State, Tribal, Local, and Territorial (STLT) Workgroup; the Policy Workgroup; the Communications Workgroup; the Health Disparities Subcommittee (HDS); and the Ethics Subcommittee; as well as a budget update and a discussion of cross-cutting issues with the CDC Director and CDC staff regarding improving collaboration with state, tribal, local, and territorial (STLT) health departments.

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 8:37 a.m., noting that he and the following ACD members would rotate off of the committee after this meeting:

- ❑ Sanford (Sandy) R. Climan, MBA, MS
- ❑ Suzanne Frances Delbanco, PhD, MPH
- ❑ Mary Kelly
- ❑ Jonathan (Jack) Lord, MD

Dr. Sanchez commented that CDC is the premiere public health agency in the world. CDC rises to challenges, threats, noncommunicable disease (NCD) concerns, and health issues worldwide. He indicated that it had been an honor and privilege to serve on the ACD.

Dr. Sanchez called roll of the ACD members and established that a quorum was present in the room and via teleconference. He asked ACD members to disclose any conflicts of interest. The following ACD members disclosed the following conflicts of interest:

- ❑ Ms. Sara Rosenbaum's department receives CDC funding
- ❑ Dr. Herminia Palacio's county indirectly receives CDC funds through the state
- ❑ Dr. Alan Greenberg's department receives funding from CDC indirectly through the District of Columbia Department of Health, the Elizabeth Glaser Pediatric AIDS Foundation, and the Association of Public Health Laboratories (APHL)
- ❑ Ms. Silvia Drew Ivie's organization receives CDC grants
- ❑ Dr. Thomas Farley's department receives CDC grants
- ❑ Dr. Lynn Goldman's department receives CDC funds
- ❑ Dr. Dileep Bal's department receives funds from CDC
- ❑ Ms. Ruth Gaare Bernheim's (Chair, Ethics Subcommittee) department receives CDC funding

Director's Update and Discussion

Dr. Thomas R. Frieden (Director, CDC) welcomed the group and thanked the ACD members who were rotating off of the committee for their consistent, helpful, and constructive input.

He stressed that the CDC budget is facing steady erosion, and explained that the budget is divided into discretionary and mandatory dollars. Within the discretionary dollars, certain funds are appropriated specifically to programs, and other funds are designated as evaluation transfer dollars, which are redirected from other areas within the US Department of Health and Human Services (HHS). Congress allows an evaluation transfer percentage of about 2%, so the HHS Secretary has some discretion regarding the budget. The current administration proposes to increase that percentage to over 3%, but it is unlikely that Congress will approve that increase.

The budget authority of CDC has been reduced by 22% from fiscal year (FY) 2010 to the proposal for FY 2013. Evaluation transfer dollars and the Prevention Fund account for the difference. The Prevention Fund is complex. When the FY 2013 budget was proposed, the total Prevention Fund was $1.25 billion. Since then, the "doc-fix" cut the Prevention Fund to $1 billion. It has not been determined where that 20% reduction will fall. Congress has suggested cutting the Prevention Fund further to pay for adjustments to the federal student loan program. Dr. Frieden believes that America is a great enough country to both educate its young people and prevent cancer. Despite these sobering facts, CDC's overall program level has not decreased dramatically, and a number of new initiatives are underway, such as the Community Transformation Grants (CTGs) and additional efforts in healthcare-associated infection (HAI) prevention; food safety; supporting state and local governments; and tobacco control.

CDC identified 6 winnable battles in which dramatic progress is possible at the national level.

Tobacco: More than half of American children are exposed to tobacco smoke. Rates decline in jurisdictions that implement tobacco control policies. Some say that tobacco has reached an "irreducible minimum." That is, the people who are still smoking are heavy smokers who will never quit. That concept has intuitive appeal, but the data prove otherwise. The bell curve has shifted so that among people who still smoke, there is a higher proportion of light smokers and some-day smokers now than a few years ago. These data reconfirm the concept that "the extreme is explained by the medium." In countries with high smoking rates, almost none of the smokers are occasional smokers. Even light smoking increases heart attack risk, however. Some jurisdictions in the US continue to implement effective programs, and some do not. The places that implement effective programs observe good outcomes. CDC has launched the first national anti-tobacco campaign titled "Tips From Former Smokers." The people who appear in the ads attended the launch event in Washington, DC. They were excited to share their stories. Calls to quit lines have doubled since the ads have begun airing, even though only 40% of the ads are tagged with the quit line number, for fear of overwhelming the quit line. Calls to the quit line have increased even more in places that are not accustomed to seeing ads of this kind.

Nutrition, Physical Activity, Obesity, and Food Safety: There have been improvements in food safety. *E. coli* infections are down by half. New York City has observed a 6% decrease in overall obesity and a 10% decrease among 5 to 6 year olds over a 5-year period. These decreases could be due to child care regulations, breastfeeding, general social awareness, or other factors. Whatever the reason, the decreases in obesity in New York City represent the first documentation on a large community basis of not only stabilization, but also reversal of trends in obesity.

Healthcare-Associated Infections: HAIs account for more than 1 million infections each year in the US, with an associated cost of $30 billion. *Clostridium difficile* is involved in the death of approximately 14,000 per year in the US. Progress has been made in this area. Central line infections decreased by nearly 1/3, saving tens of millions of dollars in healthcare costs.

Motor Vehicle Injuries: Motor vehicle injuries are still the leading cause of death among children, teens, and young adults. Nearly 33,000 people are killed in motor vehicle crashes every year, and crashes result in 3 million visits to the emergency department every year. Total costs associated with motor vehicle injuries and deaths are nearly $100 billion. In just 4 years, there has been a 20% drop in deaths. This substantial decrease is due to better cars, better roads, less drunk driving, and safer teen driving because of graduated driver licenses. Deaths among teens in motor vehicle crashes have reduced even more dramatically.

Teen Pregnancy: One thousand teens give birth every day in the US. One out of eleven new mothers is a teenager. US teen pregnancy rates are 9 times higher than many other developed countries. Teen childbearing costs US taxpayers $11 billion per year. There was a stall in the decline of rates from 2002 to 2007, but since 2007, the decline has resumed. Access to reproductive health has increased, and sexual behavior is being delayed. One concerning trend is the high cost of long-acting contraception, which is resulting in some cutbacks in services. Dr. Frieden indicated his commitment to reducing teen pregnancy because it is a major driver of social inequality in the US. Social determinants of health are more important to disease patterns than healthcare or public health. Public health can shine a light on these issues. CDC published the first-ever report on disparities and inequities, which is titled "CDC Health Disparities and Inequalities Report — United States, 2011" [*MMWR* / January 14, 2011 / Vol. 60]. A new version will be published in 2013. Public health can not only shine a light on the issue, but also can provide services and consider how to address disparities in all of its programs. The single most effective way to improve social equality is to reduce teen pregnancy, which is part of the intergenerational transmission of poverty.

HIV/AIDS: More than 1 million people in the US are living with HIV, and 1 in 5 of those infected is not aware of their status. The US spends $20 billion on domestic HIV, but only 28% of Americans living with HIV have their viral load suppressed. The first National HIV/AIDS Strategy (NHAS) points the country in the right direction. As part of the strategy, CDC is changing its grant program so that more funds are directed where they are needed most, where populations are most at risk, and to the programs that work the best. The restructuring of the grant resulted in approximately 46 states observing decreases in their funding levels. CDC did not change its funding formula based on the changing epidemiology of HIV for 20 years, so the funds got further and further away from where the epidemic was. The new formula will increase funding to some jurisdictions that do not have a great deal of capacity for HIV prevention. CDC is committed to helping

those jurisdictions. One strategy includes placing CDC staff in health departments. The cost of treating one HIV-positive person is about $400,000. The field is coalescing on a "test and treat" approach, understanding that treatment is prevention of HIV. The HIV Prevention Trials Network (HPTN) 052 Trial showed that if an HIV-positive person takes antiretroviral (ARV) drugs, the risk of spreading to a partner decreases by 96%. Utilizing this approach on a population basis could change the trajectory of the epidemic. Although only 28% of HIV positive Americans have a suppressed viral load, a rate that is lower than some countries in Africa, 11 million more Americans know their status now than knew it just 5 years ago. The goal is 90% awareness. Of the 72% of HIV positive Americans who are uncontrolled, a large proportion does not know their status and have never been tested. An even larger proportion has been tested, but has fallen out of care. The care system must have accountability.

Heart Disease and Stroke: Heart disease and stroke are the leading killers in the US. More than 2 million people suffer heart attacks and strokes. One in three American deaths is due to cardiovascular disease, and costs nearly reach $400 billion, including more than $200 billion in medical care costs. CDC has set the goal to prevent 1 million heart attacks and strokes in the next 5 years by reducing the need for treatment through community prevention, tobacco control, reducing sodium, and eliminating trans fat. Improving the quality of treatment will also reduce the number of heart attacks and strokes with the ABCs: aspirin, blood pressure, cholesterol, and smoking cessation. Blood pressure control is an area of particular concern. More than 36 million Americans have high blood pressure that is not under control and are therefore at high risk of heart attack and stroke. It is possible to increase by 10 million the number of Americans whose blood pressure is under control in less than 5 years. Providers will help reach this goal. Health Information Technology (HIT) will also play a role in reaching the goal. HIT is advancing by leaps and bounds. In just a few years, the number of primary care doctors with electronic health records (EHRs) has increased from less than 2% to more than 40%. Clinical innovation, especially team-based care, will be critical to improving blood pressure control. Team-based care also improves quality and reduces costs. Reaching these goals means that at least 4 million fewer Americans will smoke, and at least 10 million more Americans with high blood pressure will have it under control. These reductions will contribute to 1 million fewer heart attacks and strokes in the next 5 years.

Prescription Drug Abuse and Overdose: Prescription drug abuse is a public health epidemic. Every year, more people die from prescription drug, specifically opiate overdose than from heroin and cocaine combined. The US has experienced a four-fold increase in opiate deaths, paralleling the increase in prescriptions. Costs to the healthcare system are more than $70 billion per year. Enough narcotics are prescribed in the US to provide every adult American with a narcotic every 4 hours for 1 month. Several strategies will address this problem. Providers need education regarding clinical guidelines. For instance, many emergency departments will not prescribe long-acting opiates. Increasing access to substance abuse treatment will help address the problem as well. Strengthening prescription drug monitoring programs (PDMPs) will allow for appropriate intervention when patients and providers are prescribing or using drugs inappropriately. The problem of prescription drug abuse involves 2 groups: patients who are addicted, and doctors who are not aware of how risky these drugs are. People who are in pain need relief, but use of opiates for care of long-term chronic pain has marginal or unproven efficacy and carries enormous risk. A small proportion of patients acquire drugs to sell them, and a small proportion of doctors sell prescriptions at "drug pushers." This small proportion accounts for a significant number of prescriptions. In fact, 3% of all

doctors prescribe 62% of all opiates. Some of those providers are in pain clinics, but not all of them. PDMPs and similar programs can find patients and doctors who are using more than expected and intervene. Pharmacy benefit managers can play a significant role in enforcing laws, policies, and regulations.

Dr. Frieden turned to CDC organizational updates, reporting that all of the new offices that were created as part of the Organizational Improvement (OI) process will undergo review to ensure that they have met their intent. The Office of Surveillance, Epidemiology, and Laboratory Services (OSELS) has already undergone its review.

The Office of State, Territorial and Tribal Support (OSTLTS) is creating a Field Services Office to support CDC's current field staff and assist with imbedding more field staff in health departments. The new office will measure the impact of field staff in training, evaluation, tracking, and monitoring. It is important to measure not only the imbedded staff, but also all of the personnel who work with state and local health departments to ensure consistency, to identify best practices, and to optimize the grant process. The Public Health Associate Program (PHAP) is a 2-year program embedded at a state or local health department. The program is designed for young public health professionals. When Dr. Frieden joined CDC, PHAP included 15 people per year. Starting in July 2012, over 90 associates will join the program. Many CDC centers are funding associates in their specific areas. The associates are now filling key positions in public health at the state, local, and federal levels. This important program capitalizes on the wave of enthusiasm for public health and encourages young people to do great work.

The issue of lobbying has drawn recent interest. Laws pertaining to lobbying date back nearly 100 years. CDC grant conditions restrict lobbying, and grantees receive guidance and training on the issue. Lobbying is receiving new attention because of Congressional oversight of policy activities of the Communities Putting Prevention to Work (CPPW) program and the Community Transformation Grant (CTG) program. New language in the FY 2012 appropriation reinforces longstanding prohibitions and serves as a reminder of Congressional intent. The language expands the definition of lobbying beyond legislative bodies to executive agencies. No group with federal funding has ever been able to use those funds to lobby the state legislature. With the new language, groups cannot lobby the school board for safer food, for example, or the executive branch to issue childcare regulations. CDC still has a clear voice in policy. State and local governments are not affected by the new language, but the change emphasizes the need to pay careful attention to the context of the policy environment, administration positions, and Congressional guidance on appropriations. A key ethical concept is avoiding both impropriety and the appearance of impropriety. CDC has thoroughly responded to issues raised regarding its grantees. An instance of inappropriate activity was identified and CDC withdrew funds from that organization. CDC focuses on educating grantees and helping them understand the implications of different courses of action.

CDC has a strong global health presence, with over 300 hires in 55 countries and over 40 staff embedded in international organizations, as well as strong host country staff. The agency sent over 2000 people on more than 5000 trips to provide expert assistance in 300 locations in 156 countries. The Center for Global Health (CGH) has completed a global health strategy, which focuses on health impact, health security, health capacity, and improving CGH's ability to manage global health. CGH is 2 years old, and its review is pending. The center has made a great deal of progress.

In partnership with Rotary International, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), CDC launched the Global Polio Eradication Initiative in 1988. At that time, 1000 children were disabled by polio every day. By 2006, polio was found in only 4 countries: India, Nigeria, Pakistan, and Afghanistan. Unfortunately, "the ball was dropped," and widespread transmission returned. By 2011, an importation belt emerged and transmission was reestablished in some countries. Endemic polio remained in India, Nigeria, Pakistan, and Afghanistan. India put tremendous effort into polio eradication, and the country was declared polio-free in early 2012. The effort included 1 billion vaccinations per year, a $1 billion investment from the Indian government, and 60,000 children with weakness were reported to find the last case of polio in India on January 13, 2011. India made polio a social movement, not just a public health movement. CDC doctors and staff, through WHO, have helped India run its polio program for a long time. Dr. Hamid Jafari told Dr. Frieden about many innovations that helped India "get over the finish line." Their strategies included vaccinating at night; vaccinating children as they debarked from trains; utilizing males and females to provide vaccinations; naming leaders in each community to engage in refusal reversal with parents who refused to allow their children to be vaccinated; gathering data on a daily basis; returning to areas to vaccinate children who were not included in initial visits; and information technology (IT). Fundamentally, however, the success was due to an inescapable accountability process. India created a data system so that they could see where the efforts were succeeding and where they were not succeeding. The chief administrative and political officer of every jurisdiction and district in India committed to the effort, becoming personally accountable for their program's progress.

Widespread polio transmission continues in Nigeria, Pakistan, and Afghanistan, and transmission has been reestablished in 3 countries. Dr. Frieden activated the CDC Emergency Operations Center (EOC) in December 2011, putting the weight of CDC behind polio eradication to "get over the finish line." The activation has not yet yielded significant epidemiologic changes, but significant program changes have taken place. CDC has strengthened its programs in Nigeria and works with WHO in Pakistan and Afghanistan. The Pakistani Prime Minister attended a meeting of former Commonwealth countries in Australia, and after the meeting, he sharpened his focus on polio eradication.

The end of AIDS has begun. Funding for domestic treatment and care for HIV/AIDS has increased. The President's Emergency Plan for AIDS Relief (PEPFAR) targets have expanded so that within the next 19 to 20 months, the number of people throughout the world on treatment for HIV through PEPFAR support will increase from 4 million to 6 million. The number of pregnant women who are HIV positive and who receive ARV will increase so that 1.5 million women will have a chance to have HIV-free babies. In 2011, more than 660,000 pregnant women received HIV treatment during their pregnancy, preventing more than 200,000 babies from being born with HIV. PEPFAR treated 3.9 million HIV positive people, allowing them to remain productive.

CDC is an important partner in malaria efforts. With United States Agency for International Development (USAID) and the Presidential Malaria Initiative, CDC has contributed to reducing all-cause mortality in children under 5 by 16-50% in the 10 Presidential Malaria Initiative countries.

In recent years, CDC has provided rapid response to nearly 1000 outbreaks and public health emergencies in dozens of countries. The Field Epidemiology Training Program (FETP) investigated more than 300 outbreaks in 2011, conducted more than 200 planned investigations, and completed more than 300 surveillance evaluations in more than 40 countries. CDC is translating the Epidemic Intelligence Service (EIS) model for countries throughout the world, transforming their health systems. Of the EIS graduates, 80% remain in-country and become leaders in health.

CDC has a strong presence in global immunization. Measles deaths have declined by 80% worldwide, which prevented more than 10 million deaths. CDC is also focusing on building Haiti "back better than before." The cholera response helped prevent more than 9000 deaths.

Dr. Frieden concluded that, "CDC is here 24/7 to protect Americans from threats, whether they arise in this country or anywhere in the world. We save lives, we protect people, and we save money through prevention."

Discussion Points

Dr. Farley asked about the pool of CDC staff members who are imbedded in state and local health departments. In the past, the pool of public health advisors was not always well-trained to carry out other functions and roles at state and local health departments.

Dr. Frieden replied that the new PHAP replaces the former public health advisor system. Until 1993, 200 new public health advisors came in per year. About half of them stayed in public health, and about half of those who remained, remained at the federal level. The system ensured a constant stream of public health professionals entering the field. PHAP will reinvigorate that stream of people who remain in public health in the long-term.

Dr. Monroe (Director, OSTLTS) said because of support across CDC, the incoming PHAP class numbers 93. Most of the students have Bachelor's degrees, and about 1/3 of them have Master's degrees. The caliber of student is tremendous. PHAP provides a different experience from the prior public health advisor program. The students will be better trained to serve the needs of public health. The program is dynamic and growing, and they welcome input to make improvements.

Dr. Frieden said that the Field Services Office in OSTLTS is a mechanism for providing support, training, skills-building, and placement assistance for people in state and local health to help them be more effective.

Dr. Sanchez serves on the advisory board for the Texas A&M School of Rural Public Health. He has observed that students who are graduating are stepping into roles for which they may not be well-suited. He suggested generating a list of skills and competencies that a graduate from a school of public health should acquire so that the first job placement is successful. Schools of public health would likely welcome that conversation, and local health departments would likely welcome different placements.

Dr. Bal noted that Dr. Frieden highlighted spectacular results in tobacco control in New York City and California. Those jurisdictions began their work in tobacco and then progressed to obesity, using aggressive policy as a discreet public health intervention. New York City has a progressive mayor; however, other jurisdictions do not have this kind of support. Many leaders are advised by lawyers, whose job is to be risk-averse and to

limit action. The nature of the public health animal is to "step out." The work should be more "in your face." Further, the restrictive, lawyer-like language pertaining to CPPW does not help the cause. The language should be more permissive so that jurisdictions have the freedom to take bold steps beyond the federal government's limitations.

Dr. Frieden commented that there are important legal restrictions on what can be done with federal dollars. If CDC does not adhere to those restrictions, the dollars could be cut. While the legal restrictions can be frustrating, lawyers help them remain fully compliant while engaging in effective work.

Dr. Greenberg said that CDC does much good and could do more good with more funds. He asked whether CDC's flatlining budget and/or cuts are shared by other agencies at HHS. He also wondered what the public health community could do about the budget cuts and flatlining, short of lobbying.

Dr. Frieden said that the Prevention Fund has resulted in a unique set of conditions for CDC. Some look at the CDC budget and surmise that the agency is doing fine because of the Prevention Fund budget. The Prevention Fund money is not secure, but faced with the choice of a massive budget cut or the Prevention Fund, any funds are better than none. The situation has been uniquely harsh on CDC. The dynamics around the Prevention Fund are challenging. Many advocacy groups are pushing for the fund. One of public health's challenges is that they tend to be "good for a lot of people a little bit," while some people do not like what public health does, for philosophical or economic reasons. State and local governments receive 60% of CDC's funds, and they tend not to be effective in encouraging legislators to preserve funding. CDC is discovering ways to make clear what would happen if the agency's budget were cut. Sequestration would cut CDC's budget by approximately 8%. The cut would likely be spread across the agency, but it is equivalent to eliminating the entire immunization program, or several centers, or most of the HIV prevention program. CDC protects Americans from threats to their health. When Dr. Frieden took the position of CDC Director, a Senator advised him, "Never tell us the good things that are going to happen if we give you money. Tell us the bad things that are going to happen to us if we don't give you money." Congress makes the budget choices, but CDC can make the implications of those choices clear.

Dr. Goldman said that it would be helpful to understand the lobbying issue from CDC's perspective. For instance, people and organizations at her school support the CDC and are allowed to lobby. Would her school be allowed to contribute to such an organization, given that the school has projects that are funded by CDC? The school would not use the grant funds as part of the contribution, but she wondered whether conducting projects funded by CDC puts a school in a position where it cannot contribute to those organizations. Schools of public health are generally concerned about the CDC budget, not just because of concern about CDC specifically, but because of larger concern about the public's health. On the topic of prescription drug abuse, she noted that her school struggles with this significant problem on campus. They have begun work to engage the student health system and the student body. College campuses all over the country are also grappling with prescription drugs, and CDC could work with colleges and universities involved in this education in addition to the work that the campuses do in alcohol abuse and other drugs. A death on their campus was a "wake-up call" for their community. She agreed with Dr. Sanchez's suggestion regarding practical skills for students of public health. Schools would be interested in improving the practicum experience, and better

engagement with public health agencies will improve students' productivity and other workforce issues.

Dr. Frieden said that they would follow up on the question regarding advocacy organizations and schools of public health. CDC's epidemiology unit is pursuing developing web-based "quick learns" with schools.

Dr. Iton understood that the grantees' work plan for the CTG does not include the word "policy." He asked whether that was the case and about the rationale for removing the word. Dr. Goldman indicated the same understanding.

Dr. Frieden said that there have been efforts with CTG to avoid the Congressional inquiries that focused on CPPW. These efforts have focused on more clarity regarding what can be done and on leaving less open to misinterpretation. Dr. Arias (Deputy Director, CDC) indicated that she would follow up on the question.

Dr. Chu commented on the sweep of CDC's global programs and on the progress that the programs are making. He asked about elements of the global work that could be applicable to the US, such as the campaign for chronic disease prevention, the concept of a primary care medical home, imbedding nurses in primary care practices, and community health workers. The mobilization of community resources at multiple tiers and level can make a big difference. Further, he asked about public health principles in the developing world that might have application in the US.

Dr. Frieden has been impressed that while some countries like the Healthy People 2020 process, they choose instead to focus on a few areas and "really get it done." The scale-up of HIV, TB, and malaria control has proved the importance of a technical package, which is a set of tools or tasks that lead to results, and the standardization of treatment and management. Standardizing treatment leads to better quality at lower cost, and it can be conducted by a wider range of healthcare professionals. While this approach does not individualize treatment, when treatment is individualized, adequate treatment is not provided to a large number of people. Kaiser's Aspirin, Lisinopril, and Lovastatin (ALL) program is an excellent example of standardized treatment. Aspirin, Lisinopril, and Lovastatin is provided to all people with diabetes and has shown dramatic improvement in outcomes. Simple approaches such as ALL can be scaled. In the global context, task shifting leads to greater shared responsibility and is the only way to achieve better quality at lower cost with the same or more employment in the healthcare field.

Global Workgroup Update and Discussion

Dr. Alan Greenberg (Professor and Chair, Department of Epidemiology and Biostatistics, George Washington University School of Public Health and Health Services), Global Workgroup Chair, provided ACD with an update on the previous day's Global Workgroup (GWG) meeting. He reported that GWG was established as a new ACD workgroup in the spring of 2010 to advise the CGH on Strategy and Structure, Science and Program, and External Relations. Four GWG meetings have been convened. The meetings take place on the day prior to the ACD meeting. GWG focuses on critical strategic issues rather than on a program review. Their motto has been, "good advice, and not much of it."

GWG is comprised of 4 ACD members, 6 external experts representing a range of organizations and agencies, and international representatives. The meeting's agenda includes an update on CDC and CGH global health activities; the CGH Strategic Plan;

CGH's work in external partnerships; PEPFAR economic modeling; and global TB activities, which have not been moved into CGH.

GWG has focused on 4 themes, one of which focused on the pressing need for a strategic plan to serve as a blueprint for the center's activities. The plan presents an important opportunity 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 GWG reviewed a first draft of the plan at its 3rd meeting in October 2011. The draft included a Vision, Mission, Guiding Principles, and 13 Objectives. GWG encouraged CGH to continue to develop the plan in the next 3 to 6 months, and to include the input of CGH headquarters and field staff; other CDC centers, institutes, and offices (CIOs); other US government agencies; selected Ministries of Health (MoHs); and civil society. The process of plan development and getting intra- and extra-CDC organizational awareness and buy-in is as important as the plan itself.

GWG concluded that the near-final draft of the CGH Strategic Plan that was presented at the 4th GWG meeting reflects GWG input, both in the process by which it was created, and in its content. The document may serve as a blueprint for global health activities at CDC for many years to come. The plan embraces all of CGH and CDC's current global activities and also describes an aspirational vision for activities that the center is not currently well-funded to conduct, but that GWG feels the center could address in the years ahead.

The plan includes four high-level horizontal goals. *Health Impact* includes the goals of the vertical programs, such as vaccine-preventable diseases, but also new areas, such as maternal and child health and NCDs, which are more aspirational in nature. *Health Security* incorporates detection of, and response to, public health threats. *Health Capacity* addresses building public health infrastructure in collaboration with MoHs in a manner parallel to the ways that CDC has worked with state health departments in the US. The 4th goal concerns the center's *Organizational Capacity*, as the center must function at a high level of efficacy.

GWG did not engage in a group edit, but offered general feedback and priorities. GWG encouraged CGH to incorporate biosecurity and laboratory diagnostics into the plan. CGH should also articulate how its plan is synergistic with, and relates to, other US government global health strategic plans, particularly the newly-released plans from HHS and USAID. The plan process should ensure the review and buy-in of other US government agencies, civil society, and communities. CGH did a remarkable job of including input from individuals and entities internal and external to CDC, but some groups had not had an opportunity to review the draft and provide input. Cooperation and collaboration with those partners will be critical for the implementation of the plan. Civil society and communities should also be engaged in the process, as grassroots input will bring the voices of the people who will be impacted by the plan.

Now that the plan is established, the next step is for CGH to establish what to do with it. The rollout of the plan is important, as it is important for partners to understand what CDC does. The range and scope of CDC's global activities is not well-known to other agencies or to the general public. The plan presents an opportunity to package and publicize what CDC does. GWG encouraged CGH to develop an implementation plan so the strategic plan "does not gather dust." For instance, the landmark National HIV/AIDS Strategy (NHAS) was accompanied by a federal implementation plan that specified the players in

the federal government that were responsible for aspects of the plan. An implementation plan for the CGH Strategic Plan will allow the programs, divisions, and offices within the center to take ownership of operationalizing the plan. GWG encouraged CGH to prioritize the elements of the plan that the center is not yet doing. GWG also discussed partnerships and recommended that the center allow the plan to drive the development of its strategic partnerships in the federal government and in the private sector.

Another major theme of GWG's deliberations has been envisioning the potential of the CGH related to public health infrastructure. The center has a historic opportunity to be transformative, and the current fiscal challenges should not lead to a lack of ambition or vision. CDC's current emergency response approach could be converted to a more strategic approach, in which CDC partners with MoHs to build their infrastructure. These ideas are incorporated into the CGH Strategic Plan.

GWG has also focused on CGH's role in NCDs. Of the center's entire budget, only $3+ million is devoted to NCDs. The epidemiology clearly indicates that NCDs are becoming major drivers of morbidity and mortality in the developing world. There is a critical opportunity to position CDC as a global leader in NCDs, especially given CDC's legacy in working in this area domestically. CGH has made progress by creating a cross-center NCD workgroup, a senior position in the CGH Office of the Director, and a plan to assign global NCD staff. This work lays the foundation for a future in which more and more funds will focus on NCDs. By making strategic investments now, CDC can accomplish a great deal by dedicating a modest amount of fiscal and human resources to NCDs. The CGH Strategic Plan addresses and describes a visionary plan for global NCDs.

The theme of partnerships is central to GWG. CGH has made extensive internal progress in establishing connectivity with other CIOs, who support the creation of a central entity to manage CDC's global health work. GWG observed less evidence of a strategic approach to developing external partnerships and no organizational unit within CGH devoted to partnerships. GWG's thinking regarding partnerships evolved as a result of a presentation on partnerships with the Center for Strategic and International Studies (CSIS), the Consortium of Universities for Global Health (CUGH), and the World Bank. GWG suggested that the CGH Strategic Plan drive individual CGH programs to identify existing and aspirational partnerships that are necessary to enable them to reach their goals. The partnerships can be coordinated by CGH, as different parts of the center will interact with the same groups.

Regarding the theme of developing CDC's strategic voice, GWG noted that CGH presents an opportunity to monitor, package, and communicate the full extent of CDC's global activities. GWG has identified the need for a communications plan to develop CDC's strategic leadership voice in global health. This topic will be a focus of GWG's next meeting.

CGH is now seemingly well-established, so its overall progress and the theme that the center is impressive and off to a strong start was not discussed during this GWG meeting. Dr. Kevin De Cock, CGH Director, briefed GWG on recent editorials in *The Lancet* and the CDC response to the editorials. GWG commented that this issue has not been picked up by other scientific journals, and it was based on anonymous letters. Further, GWG commented that the manner in which an organization handles adverse publicity helps to define it. CDC was wise "to take the high road" and emphasize the depth and breadth of

its global programs. GWG was supportive of the CDC plan to request an external review of CGH.

Suggested topics for future GWG meetings include: 1) following-up on finalizing and disseminating the CGH Strategic Plan; 2) ensuring the development of the implementation plan; 3) exploring how the plan is driving strategic partnerships; 4) learning more about National Public Health Institutes, the Global Health Leadership Council, and International Health Regulations (IHR); 5) addressing the need for a communications strategy to synthesize, package, and market the full extent of CDC's global health activities; and 6) providing input on the aspirational aspects of the CGH Strategic Plan, namely NCDs and building global public health infrastructure.

Discussion Points

Dr. Kevin De Cock (Director, CGH) thanked Dr. Greenberg and GWG. GWG has been useful for its specific advice, general advocacy, and broad guidance that has been useful as well as reassuring. CGH and CDC have begun work with National Public Health Institutes in countries that have expressed interest in developing their own national public health entity or "their own CDC." The Global Health Leadership Council at CDC is an attempt to ensure that all of CDC is included in global health discussions. The council includes high-level leadership and staff from across the agency to discuss priorities and cross-cutting themes. NCDs present a conundrum as the global epidemiology is changing quickly, but the resources are not tracking with those changes. GWG might write a position paper on this disconnect, which includes US government support, for publication in political literature as well as medical literature.

Dr. Palacio noted that publicizing the scope of CDC's global activities carries potential risks as well as potential benefits. In the current climate, there is little taxpayer appetite for federal workers doing domestic work. She hoped that consideration would be given to strategic messaging so that the message does not get lost. Health security is an important element of the work in infectious disease, but the "hook" for NCDs will be different. Messages to partners should be nuanced, and serious attention should be paid to potential risks.

Dr. Greenberg concurred and said that those concerns were expressed by GWG. The risks underscore GWG's recommendation for a strategic communications plan. He commented that the workgroup needs to be repopulated and invited Dr. Palacio to join them as they begin work on the communications plan.

Ms. Rosenbaum asked about possible synergies between CGH and the US Trade Representative. Health is a major focus of US trade work, bringing possible natural marriages between public health and commerce interests overseas. A healthy population may promote the flow of commerce.

Dr. Greenberg answered that the US Trade Representative did not specifically emerge in the GWG deliberations, but felt that the US Trade Representative could be one of the strategic partners that helps to implement the strategic plan.

Dr. De Cock added that the US Trade Representative has not been raised, but noted that health diplomacy presents opportunity to partner with other US government agencies, such as the US Food and Drug Administration (FDA), who have interests in protecting the health of the US. Other arguments for global health are to protect the US, to save lives

because it is the right thing to do, and because healthy societies are more prosperous and stable.

Regarding chronic disease and working with other federal agencies, Dr. Bal recalled an example from 10 years ago when he spoke at the World Health Assembly (WHA) on behalf of the American Cancer Society, advocating for tobacco control in the US. At the same time, the US Trade Representative was "selling tobacco" all over the world. He expressed shame at some of the activities, such as printing warning labels in English on cigarette packs for Asia and Africa. CDC has a scientific and moral obligation to be a leader in global NCDs. He acknowledged the issue of resources being sent away from the US, but he felt that because the US has been a source of global tobacco companies and the cultural paradigm of fast food, the US has a moral obligation to address the problems.

Dr. Frieden thanked the GWG and Dr. Greenberg. He said he looked forward to the discussion of communications, which is an important and sometimes-frustrating area for CDC, as they struggle with publicizing the great work that is being done. For instance, CDC conducted an epidemiological assessment of the nomadic population of Nigeria that is unvaccinated for polio. This research, conducted in partnership with USAID, will lead to saving lives. The case for global health is strong: "We keep Americans safe, because you can't build a moat around the country." Everyone in the world is connected. CDC also keeps Americans safe through "soft power," as it is cheaper to give vaccinations than to go to war. Further, global health keeps Americans safe by keeping countries stable and productive. Global health is also the right thing to do, and this concept touches both political parties. PEPFAR was begun under George W. Bush and would not have occurred without his leadership. Dr. Frieden recalled a meeting with a Republican Senator who is supportive of global health. The Senator said that he supports global health "because it's the right thing to do." Health economics focus on cost-effectiveness, cost savings, and return on investment. Ultimately, the case for health is that it is better to be alive than dead, and better to be healthy than sick. CDC has been subject to strong Congressional inquiries regarding global NCD work. These inquiries may not be unrelated to substantial efforts by lobbyists from Philip Morris at the federal and state level. In states where the information is available, the tobacco industry is the largest single lobbyist to state governments. The industry is not standing by as rates decline and policies improve. Another challenge associated with NCDs is the fact that they are non-communicable. One can catch measles from people that is not controlled overseas. The same is not so true of NCDs. He recalled a recent trip to Ethiopia when he presented a talk on NCDs to their health leadership. The country has significant problems with malnutrition, malaria, AIDS, TB, and more issues, so he was not sure how the talk would be received. He was virtually mobbed by the doctors, nurses, and administrators who attended the talk. They thanked him for addressing NCDs, because they are making progress on AIDS, TB, and malaria, while their population is dying of diabetes, heart attacks, and strokes. Regarding public health infrastructure, he noted that China CDC just celebrated its 10th anniversary. CDC's goal is to help countries create their own infrastructure to develop their own information and use that to improve their performance. Between PEPFAR, donors, and CDC programs, this work can be accomplished. Immunization is often a best practice in public health, and the Gates Foundation supports groups that advocate for a line in the budget for immunization. This point may seem simple, but in new democracies, the concept of adequate funding for policies to introduce new vaccines is novel. It is difficult to make a case for this work, and to do the work well. Making the case is difficult because people want to save lives, not build infrastructure.

Doing the work well requires a government system in a country that may have transparency and confidence issues to work effectively. He was interested in GWG's thoughts on how to address those, and other challenges, in building local public health capacity.

Dr. Bal indicated his interest in joining GWG.

Dr. Greenberg said that CGH had asked him to request that ACD members join them to repopulate the group.

Dr. Farley said that globally, the model has been that CDC supports countries that have very little money. The world is changing, however, and many countries that were previously seen as developing countries have economies that are growing at faster rates than the US's. It may be that CDC's budget for NCDs is less important than CDC's relationships with the countries that seek to establish their own CDCs. If anything, those countries could pay CDC to serve as global consultants and technical experts so that CDC is not necessarily the global funders. CDC could likely be more effective that way.

Dr. Frieden clarified that CDC will not fund the treatment of NCDs, but even technical assistance requires a budget. They are about meet with stakeholders to decide on global targets for NCDs for the next 15 years. CDC providing expert input into the work is critical, but it is still challenging to get funded.

Dr. Greenberg said that it was a privilege to address CDC leadership. The message from GWG to CDC leadership is that after a prolonged gestational period, a transformative document is about to be "born."

Motion

Dr. Goldman moved that ACD approve the minutes from the October 26, 2011 Global Workgroup meeting. Dr. Bal seconded the motion. The motion was approved unanimously.

State, Tribal, Local and Territorial Workgroup Update and Discussion

Dr. Sanchez reminded everyone that the ACD formally adopted recommendations from the STLT Workgroup in 2011. CDC grants improvement initiatives are being addressed and implemented throughout the agency. These initiatives include, but are not limited to, the Funding Opportunity Announcement (FOA) redesign, the Project Officer Technical Assistance Improvement Workgroup, Procurements and Grants Office (PGO) processes improvement; and increasing the use of imbedded staff. All initiatives support the STLT Workgroup recommendations from 2011, which were to: 1) engage the STLT community; 2) increase funding flexibility; 3) create standardized approaches; and 4) invest in quality improvement. The STLT Workgroup's initial discussions concerning the "Health Department of the Future" include: 1) identification of core services and programs that health departments should provide; 2) regionalization and shared services; 3) workforce development; and 4) working with clinical healthcare.

Dr. David Fleming (Chair, STLT Workgroup) updated ACD on the activities of the STLT Workgroup. Approximately 60% of CDC's budget and much of its technical expertise is operationalized at the state, tribal, local, and territorial levels. The STLT Workgroup focuses on how that job can collectively be done better. The Workgroup includes membership from the ACD and a "who's who" of leadership at the state, tribal, local, and territorial levels.

ACD passed a comprehensive package of recommendations from the STLT Workgroup at its October 2011 meeting. The recommendations focused on ways to improve the usefulness of CDC funds that go to state, tribal, local, and territorial health departments. The recommendations focus on engagement so that the cooperative agreements are truly cooperative; increasing the flexibility of the financing while maintaining strict accountability and using the funds so that they are most useful at the community level; standardizing approaches so that a single model governs the entire cooperative agreement program; and focusing in quality improvement.

Judy Monroe, (Director, OSTLTS) updated ACD on how the STLT Workgroup recommendations are being advanced at CDC. OSTLTS is coordinating its efforts with the Office of the Associate Director for Program (OADP) and the Office of the Chief Operating Officer (OCOO).

The FOA redesign is at the heart of the recommendations. A template for all new domestic non-research FOAs is being vetted at the agency. The new template captures many recommendations from the ACD. The new template will streamline the work and add consistency to it, bringing standardization across the agency. Draft guidance and a checklist will accompany the new FOA. When the comments are received from CDC, the draft FOA template will be revised and sent to the STLT community to get their input before the new template is implemented across CDC on October 1, 2012.

The Project Officer / Technical Assistance Improvement work is called the Technical Assistance Services Improvement Initiative (TASII). This initiative will improve support to all CDC project officers and help CDC better understand how project officers support the field and advance work. An All-Hands meeting with all project officers was held in October 2011. CDC has created a portal so that all of the information that project officers need is in one place. Project officers receive monthly education on a range of issues that all project officers should be aware of, including public health law, accreditation, PGO programs, the Community Guide, and others. Internal and external surveys are being conducted. The external surveys represent the first time that CDC has asked the field how its project officers are doing and how the work and training might be improved. OSTLTS has established a Field Services Office, which offers an opportunity to think about all of CDC's field staff training needs and support in a single location.

Several outcomes are desired from the FOA redesign. The standard FOA should reflect strong program strategy with the greatest health impact and ensure that the FOA investments are achieving the greatest health impact. The redesign also improves accountability for CDC programs and for grantees in the field. The redesign will improve the consistency, quality, and clarity of FOAs and improve agency collaboration. The redesign is an element of implementing the ACD recommendations related to FOA standardization, engaging external stakeholders around program design, and financing flexibility.

Examples from the proposed FOA checklist include: 1) seek meaningful input on FOA key priorities, strategies and lessons learned from a broad and representative group of external stakeholders; 2) consider whether funds from related programs can be bundled with the new FOA either now or in the future; and 3) ensure that the FOA will yield data to support analysis of the value of the funding.

Dr. Fleming commented on the energy and effort that CDC has put into rethinking the FOA process.

Dr. Fleming turned to the future work of the STLT Workgroup. At the October 2011 ACD meeting, the ACD approved that the next task of the workgroup will be to create recommendations for how CDC can support the health department of the future, given this time of incredible opportunity, challenge, and transition in the field. The STLT Workgroup holds meetings at 3-month intervals between the ACD meetings. At the last meeting, the group prioritized four areas in which they can work with CDC to improve services.

In an era when budgets are declining and questions remain regarding what public health should be doing, it is important to define the essential core set of services that every health department system should provide. The US does not have a public health financing system; instead, categorical program streams fund an assortment of time-limited public health projects. Therefore, it is easy to cut those projects in funds-limited times, because they are not part of a defined whole. If things are going to change, then public health needs to define the core package of services that every resident of the US should have access to. Currently, health departments vary widely in the services that they are providing. Achieving standardization regarding services at the state and local level will require a stakeholder process to negotiate some difficult issues. The process will include ways to think about how to incentivize accreditation, which can provide a basis for cross-cutting core capabilities that health departments should have.

The second area for consideration is regionalization and shared services. The design of an ideal public health system would probably not be based on over 3000 local jurisdictions providing it. Consequently, the system experiences great inefficiencies. A health department in Washington State serves 1500 total residents in a county. It is not possible for that health department to capably provide services, unless there are ways to share services or regionalize services so that the system can be efficient and comprehensive. This topic is rife with legal and political issues. Further, self-interest issues will affect the dialogue. The STLT Workgroup may recommend that CDC approach the problem from a national perspective or find a neutral convener that can help with the problem. State and local health departments are doing creative work, but there is no clearinghouse to learn about what is working in other areas. Additionally, there could be strategies within the CDC financing and cooperative agreement mechanism that could incentivize shared or regionalization of services.

The STLT Workgroup also recognized that the current public health workforce probably does not align as well as it should with the needs of the field today and in the future. Health departments are losing clinical expertise, which can link to healthcare reform. Work in systems and policies will engage non-traditional health department partners, such as transportation and parks. The public health workforce will need to conduct effective advocacy, policy development, and policy decision support, and that workforce is not in public health currently, or in training. Potential recommendations from the STLT Workgroup could focus on how CDC is a prime mover of the creation of the public health

workforce of the future. CDC can find ways to optimally align its existing training programs with the workforce of the future, or the programs could be augmented or adjusted to make them more effective. Additionally, CDC might encourage schools of public health in this area. There may be ways to retool the existing public health workforce more effectively.

The last issue concerns public health working with clinical healthcare. It is important for health departments to consider the ramifications of the Affordable Care Act (ACA) and healthcare reform. How do health departments need to change the way they do business? For instance, because of community benefit, a number of hospital systems will devote new resources to advance community health goals in jurisdictions. There are a number of barriers associated with this work. Increasingly, health departments have become distant from the clinical provider community in many jurisdictions. There is a window of opportunity to take advantage of changes in the system. The STLT Workgroup may recommend that CDC work in technical assistance, facilitation, collaboration, convening, establishing a clearinghouse, and working at the federal level to make it as easy as possible for these actions to occur at the state and local level.

Discussion Points

Dr. Frieden asked how the issue of core services relates to the accreditation issue, and about the role of IT and opportunities for savings.

Dr. Fleming replied that IT is an essential feature of shared service. Shared service will only occur if a mechanism is developed to better overcome political and cultural barriers that exist to thinking about cooperation as a loss of power. Once those initial barriers drop, progress is made naturally, including the idea that conducting IT development separately is inefficient. Regarding the package of public health services, he recalled recent recommendations from the Institute of Medicine (IOM) regarding public health financing. A component of those recommendations was creating a minimum package of public health services. The first element of this work is identifying the cross-cutting, foundational capabilities that need to be present at a health department and exist across all programs. These elements include communication, community mobilization, assessment of community health needs, policy decision support, and should not be built individually within each program, but should be a foundation upon which all programs rest. The accreditation process is a good starting place for thinking about these cross-cutting capabilities. The accreditation standards need to be more specific, as they are currently broad and general. Making these standards specific will require defining what they actually mean, prioritizing creating them, and costing them. He felt that the current accreditation standards need work to get to that point. The second piece of core services includes the program elements that rest on those cross-cutting capabilities. What are the core functions in communicable disease control, chronic disease control, injury prevention, maternal and child health, and other programs? Accreditation is not currently helpful in that domain, as it does not speak to individual programs. Even for the core capabilities that are a good start, the way that a health department meets accreditation is by providing an example of how the department met one of the core capabilities by using a specific program. This approach means that one program's strength in communications, for instance, could qualify the department for accreditation even if the strength does not extend to the rest of the department. It is important that if a health department is accredited for a cross-cutting capability, the capability should be resident in a cross-cutting way.

Dr. Frieden asked about the structure for addressing the accreditation issues.

Dr. Fleming felt that the stakeholder engagement process is critical. The Public Health Accreditation Board (PHAB) is a place to implement some of the changes, but the first piece of business is to secure agreement across STLT health departments and CDC leadership regarding what the core piece will look like.

Ms. Drew Ivie suggested that the core services discussion should consider the role of public health in the foster care system. Public health can play an important coordinating role between health, mental health, and social services, and no other focal point can play that role as well as public health could. The capabilities necessary for taking care of children in foster care are not present as the system is currently constructed.

Dr. Goldman suggested that the STLT Workgroup emphasize the capacity to engage in strategic planning. Many departments will likely discover gaps, and understanding what they need to do first may be challenging.

Dr. Fleming agreed. One of the core abilities of a program is the ability to work with stakeholders to develop a plan.

Dr. Greenberg commented on the complementary nature of the global and domestic issues. He suggested that CDC take advantage of the opportunity for the "left hand to inform what the right hand is doing." The CGH Global Strategic Plan states that CDC "seeks to help countries build capacity related to epidemiologic surveillance, laboratory diagnostics, workforce, research, strategic information, expenditure and costing analysis, and outbreak response." There must be overlap between how CDC helps health departments and how CDC helps MoHs, and discovering the commonalities will likely help both causes.

Dr. Fleming concurred and added that a key element of this work will be for everyone to acknowledge that they cannot do everything in public health. This work will be an exercise in meaningful prioritization.

Dr. Chu appreciated the ideas regarding stimulating collaboration and shared services as well as the ideas to economize and reach an accreditation process that focuses on core capabilities and core programs. He felt that this direction is appropriate, especially given diminishing funding resources across the country. He asked whether the workgroup had discussed core metrics. The field is coalescing around core measures of performance that can be standardized, nationalized, and benchmarked. Performance outcomes could be important in measuring health departments across the country, but could be controversial.

Dr. Fleming said that metrics had not been explicitly raised in the workgroup discussions. The October 2011 recommendations touch on the need to improve thinking on metrics, which are a critical element of accountability.

Ms. Rosenbaum referred to assets that CDC could deploy to assist with the effort to modernize the functionality of public health at the local level. She said that the Prevention Research Centers (PRCs) are imbedded in universities around the country and wondered whether they could be corralled to provide an evidence database and address various issues that will arise in the core competencies. This approach will assure a constant

source of incoming information, because CDC will need a strong evidence base for solutions and action. The issue of legal authority to act is important as well. CDC has given attention to the modernization of public health law, and she wondered whether there should be alignment between people who work on public health legal authority and CDC's work to operationalize public health activities. With this alignment, CDC will learn where to be strong and where it has the authority to act. Public health law experts can utilize empirical evidence to feed model statutory development.

Dr. Isham said that the STLT Workgroup report sets the stage for moving the IOM recommendations forward. He agreed with the comments regarding accreditation. The process should be critiqued and tightened in a manner that will assure the public that they are getting the best they can. As part of the publicity for the IOM report, he spoke about a tax to raise money for public health. The reflex reaction from across the political spectrum told him that it was unlikely that investing in public health will come from mechanisms that raise taxes. In bringing stakeholders together to package essential services, a rationale should be developed for why each element of that package is vital to the safety and health of the public and the nation. The other two reports in the IOM series addressed law and policy, and metrics. Jurisdictions should strive to link their metrics of performance not only to process, but also to outcomes in different jurisdictions against a national infrastructure. The infrastructure should emphasize how important public health is to promoting community health. He offered his vote of confidence to the work of the STLT Workgroup.

Mr. Andrew Rein said that core services will probably change in the future. The changing environment and the ACA offer opportunities as well as challenges. The public health system's relationship with clinical systems, surveillance systems, and outreach systems will be affected by the ACA. The work on core services should take the other systems into account, how they will change, and what public health should be doing.

Dr. Sanchez said that the public health accreditation process cannot be siloed from the clinical care system. This work can better articulate the interdependence of the two systems. People in clinical care may not see the interconnectedness. Collaboration ought to include how public health should be "at the HIT table and the Health Information Exchange (HIE) table." There is value in including the public frame in how data exchange is turned into action. It is also important to "be at the Accountable Care Organization (ACO) table." ACOs will need to acknowledge and support the public health functionality that needs to be present in jurisdictions. There is a difference between public health services and public health benefits. An individual receives benefits, which are different from the services that the medical care delivery system should be prepared to deliver. For the individual American, the benefit notion is more attractive than what the infrastructure will look like. These conversations must include more than "the usual suspects." The PRCs could be a strong academic partner, and representatives from corporate clinical medicine and in non-clinical corporate America will help inform these issues and help generate ideas for how to pay for these services in a way that will flow from the IOM work.

Policy Workgroup Update and Discussion

Sara Rosenbaum greeted ACD and thanked them for the opportunity to present an update from the Policy Workgroup, which has been underway for a number of months. She explained that the purpose of the workgroup is to help support CDC's strategic priorities, using scientific and program expertise to advance policy changes that promote health. The workgroup provides input to the CDC on policy strategy and implementation. They

provide support to CDC staff who is engaged in the development of policy, holding regular meetings and conducting regular communication and updates.

Like other workgroups, the Policy Workgroup addresses a number of topics that are complex and important to the CDC: 1) prescription drug overdose; 2) enhancing CDC policy effectiveness, especially in Washington, DC; 3) the issue of community health needs assessment and hospital community benefit, which has been discussed by other groups; and 4) making the case for prevention and how to measure the economic and budget impact of both CDC programs and activities and health interventions more broadly.

Dr. Linda Degutis, Director of the National Center for Injury Prevention and Control (NCIPC), provided the workgroup with an overview prescription drug abuse in the US, including the burden of the problem, promising practices, and interventions. The group considered several questions for consideration and input:

- ❑ What are CDC's strengths, activities, and role in this area?
- ❑ Where are the best opportunities to link mental health and public health?
- ❑ Where are the best partnering opportunities, both government-wide and HHS-specific as well as extramural partnerships, especially related to cost?
- ❑ What are potential funding mechanisms for PDMPs, law enforcement access to PDMPs, including databases, and who has access to them?
- ❑ Are there other policy strategies that would address the problem?

Ms. Rosenbaum shared an encounter she had with a group from the Association of State and Territorial Health Officials (ASTHO) who were in Atlanta to discuss prescription drug overdose issues and public health. The ASTHO representatives identified four specific issues for the Policy Workgroup and for the ACD. First, a comprehensive public health strategy is needed for the problem. Prescription drug abuse is a problem for law enforcement for both providers and patients, and while the problem is centered in healthcare, the public health approach is being lost. There is a group of patients who are in pain who are not handling their drug regimens well, and physicians who are not managing the drug regimens appropriately. The ASTHO representatives also indicated that they lack an evidence base for public health solutions. They need guidance and standardized solutions to these complex problems. They would appreciate more robust, evidence-based guidelines for assessment and treatment, and they would appreciate models of prevention.

The Policy Workgroup discussions addressed a number of concerns with prescription drug abuse. Better policy data are needed. Research should focus on claims data and payment patterns. Further, research should analyze state variation data in sales, deaths, and other outcomes. The group suggested developing and disseminating a tool kit to states to promote promising practices and reaching out to State Medicaid Directors. This problem is disproportionately concentrated in lower-income patients who depend on public financing. They are more at risk for developing this abuse for many reasons. They are more vulnerable, many of them are in chronically poor health and experience a great deal of pain, and their access to care is not good. The workgroup supported sharing information across emergency departments in a manner similar to the strong work in Camden, New Jersey. Legal and privacy issues are associated with PDMPs and should be addressed. The group suggested enhancing mechanisms related to how medical care is overseen, such as physician peer review and medication surveillance. These

mechanisms can alert care managers in insurance plans and provide an area of interaction between public health and health insurers and benefit plans.

The Policy Workgroup has also addressed the issue of enhancing CDC policy effectiveness. Ed Hunter, Director, CDC Washington, provided the group with an overview of CDC policy goals, the federal and state policy environment, and potential leverage points. The situation has changed since the presentation, but the following significant issues continue:

- Where should CDC focus for its greatest impact in 2012?
- What do policymakers need to know?
- Which issues are priority issues?
- How can CDC translate that evidence-based knowledge into policy development in Washington?

Specific initiatives could be implemented in executive action; federal legislation; state-focused policy initiatives; and laying the groundwork for upcoming initiatives, such as the relationship between public health and health insurance exchanges.

Regarding enhancing CDC policy effectiveness, the group suggested that CDC focus on funding for public health. CDC can represent the entire public health field and maintain a broad framework for thinking about public health investments. CDC can consider executive actions that various agencies and the White House can do to position public health and ensure no further erosion of public health funding. The group discussed the reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA) and the importance of thinking about policy positions that should be developed as the reauthorization process begins. CDC could explore the applicability of private sector models, such as social impact bonds. The group discussed how to utilize issues such as the development of ACOs, which may not seem to relate to public health policy, to promote public health policy. Funding should be tied to performance indicators and measures of accountability. In policy, there is always a strong need for synergy between federal, state, and local policymaking activities. The work of the Policy Workgroup relates to the STLT Workgroup's work on the health department of the future. There is a need for shared guidance on health impact assessments (HIAs) and model state laws and tool kits.

The Policy Workgroup has also addressed community health needs assessment (CHNA). Paul Stange and Chesley Richards, Director, Office of Prevention through Healthcare, provided the group with a presentation on the issue, which has emerged in other workgroups and subcommittees of the ACD. The ACA includes revisions of federal tax policies relating to nonprofit hospitals. Nonprofit hospitals have always had a community benefit obligation to invest in their community. In recent years, the community benefit obligation has been taken more seriously, and the ACA reforms are designed to focus on the relationship between hospital community benefit investments and communities. The ACA requires hospitals to develop a more robust and transparent needs assessment process. Hospitals are also required to develop an Implementation Strategy, which is the decision of where the hospital will invest its resources. The Implementation Strategy is a separate step, but the strategies will be attached to hospitals' Internal Revenue Service (IRS) 990 forms, so everyone can see where hospitals' investments are going. Under IRS guidelines, an investment in what public health would call "upstream activities" is a community benefit, bringing opportunities for synergies. For instance, a hospital may invest its funds in indigent care, which is an area of great need. A hospital could invest its

funds in participation in government insurance programs, recognizing their losses as a community benefit. Their accounting losses for participating in research are also recognized as a community benefit. Community benefits also include activities such as awarding grants for clinical preventive services outside the hospital; investing in health workforce training; introducing school health programs; or investing in improved housing, improved employment training, safe neighborhoods, safer streets, or parks and areas. Because of changes in IRS guidelines, activities and initiatives with a connection to public health can represent a community benefit investment. The next step is to engage with hospitals in joint planning and thinking about upstream investments. The magnitude of the community benefit obligation dwarfs the Prevention Fund. The Government Accountability Office (GAO) attached a $15 billion figure to the obligation in 2002, so it could be at least double that much now. Even if a small amount of this obligation were devoted to upstream investments, it would be beneficial for public health.

The Policy Workgroup discussion addressed how CDC can engage hospitals in upstream investments, promoting joint planning activities. Many hospitals already engage in joint planning. The law requires that hospitals bring public health input into their plan development, and the group discussed how CDC could better support that process. For instance, models and tools could be made available. The group discussed how to ensure that the full range of public health investments, even activities that are not clinical care-related, are recognized as investments that are a community benefit. The group discussed how best to promote consultation between hospitals and public health agencies and how to aid hospitals in thinking not just about their market areas, but about the broader regions that they serve. Thinking about areas geographically will lead not only to upstream investments in terms of need, but also broader investments in populations that do not necessarily present at the emergency department, but who are underserved. Further, the group discussed how to being greater transparency to the planning and implementation processes.

Regarding making the case for prevention, the Policy Workgroup heard a presentation from Kakoli Roy, Policy Research, Analysis, and Development Office. The overview gave the group insight into how CDC is making the case for prevention and how CDC sets standards and guidelines to ensure the quality, availability, and appropriate use of economic and budget impact information. The presentation also addressed how CDC synthesizes the best evidence available to demonstrate the value of CDC programs and activities. This issue is particularly important for the workgroup. The group discussed whether the program is on the right track and whether it should have a broad or a specific focus. The group generated suggestions for improving or leveraging this work to enhance impact and whether the work could build on other, similar initiatives focusing on the benefit of preventive investments. The group said that CDC plays a significant role in informing other efforts. CDC's economic impact data studies should be considered in an all-agency context. As CDC amasses this evidence, it is important to consider what the Office of Management and Budget (OMB) and the Congressional Budget Office (CBO) use as evidence. Dialogue with other cost estimators in health is important for CDC. The group also suggested communicating the value of investments as well as what could be lost without investment. CDC should also consider the messengers and the audience. The group suggested that CDC talk to private sector representatives about the health information that they would like about a community.

Discussion Points

Dr. Sanchez said that state boards of medical practice could be strong partners. There is a national association of these boards, which is a potential pathway. He pointed out that the term "behavioral health" rather than "mental health" is used in reference to substance abuse and drugs. He also suggested that hospital councils could provide a means to jump-start conversations about community benefit. Some hospitals and councils are already thinking about these areas.

Dr. Frieden asked Dr. Chu, Dr. Isham and others in the clinical realm to comment on the community needs assessment and the 990 requirement. He asked for their sense of what is likely to happen, given the fear that the activities could be low-impact.

Dr. Sanchez said that the Dallas-Fort Worth Hospital Council is thinking in a progressive manner, and he felt that some hospitals and groups realize that if the work is not done right, then everyone will suffer.

Dr. Chu felt that this was a great direction. In his work with the American Hospital Association (AHA) and in discussions with how to approach the community benefit investments, he has observed the notion that hospitals understand the need to "go upstream." Hospitals realize that being at the "end of the health food chain" and focusing only on disease and acute illnesses is not the best or most value-driven approach. In its redevelopment of its health reform framework, the AHA focused on being part of the dialogue around going further upstream. He felt that public health would find willing partners who appreciate the need to be more expansive about community benefits.

Dr. Isham offered an example of small rural hospitals in the Wisconsin health system that have formed a not-for-profit corporation with the involvement of local public health in their county. Together, they consider health issues generated by the state and are collectively investing their public health dollars to affect the issue of fluoridation in water. This example illustrates a mechanism for a partnership between public health and hospitals. He hoped to see local hospitals work with their local health departments to use data and information to decide how to invest in an issue that is important to the locality. It is then possible to critique whether they have done the work well. From the hospital side, he has heard concerns regarding ensuring that this initiative is not another mechanism for subsidizing activities that should already take place through taxation or another means for government to try to fund government.

Ms. Rosenbaum suggested that CDC has an opportunity in the expansion of the IRS definition of a community benefit. The 990 instructions indicate that the IRS will recognize a community benefit investment if a public health evidence base is provided. CDC could create a repository of literature for every state and local health department. When a hospital decides on a strategy, it will have a Web-friendly resource for the measurable public health benefit of the investment. CDC can also create a good input process to support hospital efforts and to prioritize issues.

Dr. Isham added that hospitals want to be engaged in the process, and they want to receive credit for the work.

Dr. Nisha Botchwey added another potential partner of local planners who forecast and design neighborhoods and rehabilitate communities from physical as well as

programmatic perspectives. There has been an effort to link planning departments with public health organizations, particularly concerning the health impact assessment tool.

Ms. Rosenbaum agreed and noted the relationship between these efforts and the CTG, which also addresses these issues.

Dr. Iton commented on the Joint Metrics Development Effort. The regional Federal Reserve Banks have been engaged over the past 18 months in 11 regional meetings on community economic development and the overlap with social determinants of health, particularly the ability of social determinants of health perspectives to guide economic development. The banks are a great partner in developing metrics and planning strategies that dovetail with public health strategies. The banks legitimate many of the social determinants of health strategies that public health departments are developing around the country.

Dr. Isham commented on an opportunity to partner with the regional Federal Reserve Banks on the health measures that they use for their crediting standards, as the health measures are somewhat rudimentary. Those measures can be aligned with community development through financing institutions and to show the impact on public health.

Regarding community benefit, Dr. Frieden expressed his hope that tobacco control and blood pressure would be two key areas for collaboration. Funding advertisements, community blood pressure checks, systems to improve care, or exercise programs are all possible areas for collaboration. Other topics may be more locally relevant, such as teen pregnancy, HIV, or HAIs.

Ms. Rosenbaum said she hoped that they would go right down the list of all the CDC priority areas and develop an evidence base for each area that is easily accessible by hospitals. The resource could include model programs and a way to access information and the public health input process.

Communications Workgroup Update and Discussion

Dr. Sanchez introduced the Communications Workgroup, thanking Mr. Climan for lending his expertise to the workgroup and serving as its chair. As Mr. Climan is rotating off of ACD, the Communications Workgroup is in need of a new chair.

Mr. Climan (Chair, Communications Workgroup) thanked Dr. Frieden and the ACD for recognizing the importance of communication. The ACD can provide a valuable external perspective, and the ACD's advice regarding increasing engagement and interaction is providing direction for the CDC's work and products. The Communications Workgroup proposes that the workgroup can serve best as a consultative body, much like a focus group or panel for on-going CDC communication and marketing issues, questions, and challenges. The workgroup proposes to continue to work with CDC's Communications Director on these tasks. While his tenure on the ACD is ending soon, Mr. Climan has pledged to remain a contributing member of the Communications Workgroup. Two of the four group members are rotating off of the ACD, and he asked ACD members to consider serving on the group and to think of external members who could assist the group. He commented on the great strides that have been made in the 4 years that he has been part of the ACD.

Katherine Lyon Daniel, BA, PhD (Acting Associate Director for Communication), shared a video that illustrates CDC's work and purpose. She described a recent retreat for CDC Communications staff and other CDC staff who work on CDC's winnable battles. The retreat included opportunities for participants to engage in strategic planning for each of the winnable battles. As an icebreaker, the facilitator of the retreat asked each participant to share a metaphor for his or her work. Two of the notable metaphors were, "It's like a jet refueling in mid-air. It's extremely stressful, very high speed, but you have to do it to get to where you need to be" and "We feel like pieces of fruit in a blender, and somebody's finger is on the 'pulse' button. We know that it's going to be hard for a little while, but at the end, we're going to have a delicious, healthy smoothie." The metaphors described the struggle and intensity of the work, but they all focused on outcomes.

The input from ACD and the work of the Communications Workgroup suggested that CDC concentrate on being more proactive and engaged as it moves forward. The Communications staff has undertaken three priorities to make CDC's messages, information, and materials more 1) accessible; 2) understandable; and 3) actionable. Several activities address these priorities. *Vital Signs* is a monthly publication that focuses on CDC priorities with visual graphics, understandable text, and key points of action. Communications staff from around the agency contributes to this significant effort to being science and communication together in a meaningful manner. Additionally, some high profile issues must bring science and communication together very carefully. For example, when CDC released surveillance data on autism rates, CDC worked very hard to ensure that people would receive the information, understand what the data meant, and know what to do about it. Further, the communications efforts helped people understand the importance of CDC's role in continuing to track health concerns that people care about, such as autism.

Other complex issues include sodium and trans fats. The upcoming "Weight of the Nation" conference will tackle obesity. The CDC Communications Office works with CDC programs months in advance of such events to learn about the messages that they want to convey and why CDC has a vital role in the issue or event. The Communications staff has also worked to foster two-way interaction and engagement, especially through the use of social media. A CDC app is now available for the iPhone and iPad, and staff is working on additional ways that will help people understand the work that CDC does. For example, a new "CDC Disease of the Week" application will include quizzes and other ways for people to learn about CDC's work in an interesting, fun, non-government-type approach. This will launch in summer of 2012, to be followed by a new "CDC Disease Detective" app directed for public health students and other interested people.

CDC is tracking its data online and in social media. The tracking includes not only the quantity of the communication, but also the "conversational word cloud" around CDC. It is important to understand how people are thinking and talking about CDC in order to move in the right direction. CDC utilizes a range of multimedia materials because people get information in many different ways. These materials include infographics, which help visually-oriented people understand complex topics and their impacts. Last year, the Communications Office at CDC alone produced over 9000 products for CDC, 1800 of which were directly related to the winnable battles. Much communication work is also conducted within CDC programs, especially when they are preparing for a large campaign. The CDC Communications Office helps programs around CDC have impact and build onto their work and messages to layer the efforts.

Audience research is another component of communications work. During the October 2011 meeting, Dr. Daniel related a campaign that Coca-Cola launched to link their brand to polar bear rescue. Since that meeting, it became clear that Coca-Cola missed a critical piece of audience research in their planning for the campaign. When the specially-designed products reached the market, the new polar bear cans of Coke looked too much like cans of Diet Coke. Consumers purchased the wrong product and were angry. Coca-Cola removed the new design earlier than they had planned. This example illustrates that even when millions of dollars are spent on research, it is still possible to make mistakes. Additionally, the example illustrates that you can't be too careful with audience research.

During the October 2011, ACD gave its vote of confidence to communications at CDC, and CDC leadership has indicated its confidence in communication through its three priorities of healthy organizations, partnerships, and communication. CDC leadership is working to integrate communications priorities and objectives into their programs to: 1) highlight CDC's vital role in protecting America's health; 2) create tailored messages for partners and stakeholders; and 3) provide clear, consistent, coordinated, relevant value messages. CDC's communications efforts operate with the concept of "strength in unity." When all aspects of CDC have similar, consistent messages that are shared in simple ways that people can understand and relate to, then CDC's voice is heard. Further, it is important to work with CDC's partners on unified messaging, particularly in the realm of budget and policy.

Audience research in these economic times has yielded different results from previous research. Now, issues such as health security are important. Chronic disease and other issues are important as well and should be communicated, but the language of communication should resonate with audiences. It is important to help people understand that CDC ensures health security not just by emergency preparedness and response, but also by securing a productive workforce and population and by ensuring the health of future generations so that they can live free of chronic disease. Internal reactions to CDC's messaging included a request for more data and tailored messages. The communications platform is in a good place to move CDC's 24-7 mission forward.

Dr. Daniel showed ACD a slide that all programs are asked to integrate into their presentations. The slide reinforces that CDC saves lives, protects people, and often saves money through prevention by lowering health care costs. The Communications staff has created materials, including fact sheets, including data and example of how CDC carries out its objectives. The Communications staff is working with the Policy Office on economic research to generate messages to support how CDC saves money and also to support the initiatives that may cost money, but that are the right things to do.

In closing, Dr. Daniel invited ACD members to join the Communications Workgroup. She commented on data from CDC's internal employee satisfaction survey on communications, which indicated that CDC staff wants the ability to work across divisions, branches, and activities at CDC. The Communications Office tries to make connections where possible, and an internal employee communications system facilitates those connections. She asked ACD to share their ideas and successes in creating linkages within and across their organizations.

Discussion Points

Dr. Isham commended the Communications Workgroup for doing an excellent job, noting that the changes to CDC's communications efforts have been noticeable. He asked about

CDC's linkage to the US Department of Defense (DoD), particularly regarding the issue of obesity among military recruits. This health problem lies at the core of national preparedness, and he wondered about opportunities for linkages.

Dr. Frieden answered that the National Prevention Council includes DoD, which has done important work in this area, particularly in improving food service. They are also working on tobacco policies. They also have communications mechanisms that CDC could potentially utilize.

Dr. Sanchez added that the Mission Readiness organization generated the report "Too Fat to Fight," which states that 27% of young people are rejected from the armed services.

Dr. Isham said that there are opportunities in this area to create a rationale for health within broader social issues.

Dr. Bal commented that in his experience, it is impossible to break down silos. On one hand, programs are encouraged to be "empire builders" that bring in money. On the other hand, programs are encouraged to share.

Dr. Isham and other ACD members indicated their willingness to share their thoughts regarding Dr. Daniel's question about internal connectivity with her and assured her that it was not impossible.

Dr. Sanchez thanked Dr. Daniel for her presentation. He summarized that the "24/7 message" of "We've got your back" is a great message. One way to encourage internal communication is to remind staff in different ways that the organization is focused on that message. Further, giving people a chance to engage and interact socially is a good way to break down silos in an informal manner.

Budget Update

Sherri A. Berger, MSPH (Chief Operating Officer) provided ACD with an update on CDC's budget for FY 2012 and FY 2013. She reported that CDC's budget for FY 2012 is approximately level to FY 2011. There were some big losses for CDC, including the lead poisoning prevention program, cuts to BioSense, and cuts to the Strategic National Stockpile (SNS). FY 2012 brings a few new opportunities in polio and other small programs. Overall, CDC did better than expected, given the current fiscal environment.

CDC has a new account structure, which represents a significant change for the agency. In prior years, CDC has received one main appropriation, which was accompanied by directions for how the agency should spend the funds. Starting in FY 2012, 14 separate accounts were created for CDC. Specific budget numbers are associated with immunization, chronic disease, emergency preparedness, injury, and other areas. This change has been challenging because CDC has had to remap thousands of transactions.

A government-wide rescission affected all accounts in FY 2012. CDC specifically received a $20 million cut to administrative costs and contract reduction across its programs. We believe this was done in response to an external perception that our program overhead is higher than it should be. All of HHS was subject to a 1% emergency transfer. For this, CDC contributed approximately $1 million to the Health Resources and Services Administration (HRSA) for HIV screening.

The President's budget request for FY 2013 was approximately $700 million below FY 2011. If this number becomes CDC's final appropriation, the agency will be funded at a level 22 percent, or $1.5 billion, below the FY 2010 funding level before the Prevention Fund began to offset the budget.

CDC's funds come from Congressional budget authority and from other sources within the federal government. The Public Health Service (PHS) Evaluation Transfer is a fund to which all HHS agencies contribute that is redistributed to the HHS agencies. CDC contributes approximately $80 million to the fund and receives approximately $300 million. The National Institutes of Health (NIH) contributes the most to the fund, as NIH is the largest-funded operating division within HHS with discretionary dollars. American Recovery and Reinvestment Act (ARRA) funds and ACA Prevention funds are additional sources of CDC's budget. The Public Health and Social Services Emergency Fund (PHSSEF) is the HHS Secretary's emergency fund for problems such as pandemic influenza.

CDC budget increases in FY 2013 were in the area of three winnable battles: domestic HIV/AIDS prevention, food safety, and the National Healthcare Safety Network. Increases were also received in two priority areas for CDC: health statistics and polio eradication. Significant decreases occurred in other areas of the agency. When the FY 2013 Prevention and Public Health Fund was created, $1.25 billion was available, and CDC was slated to receive approximately $900 million from the fund. After the budget was released, Congress used some of those funds to offset other areas of deficit. $1 billion is now available in the Fund.

CDC's program-level request for 2013 is $664 million below FY 2012. An increase is reflected in the PHS Evaluation Transfer because the FY 2013 President's budget moves the National Institute for Occupational Safety and Health (NIOSH) to that fund. Funding for the Agency for Toxic Substances and Disease Registry (ATSDR) is level, PHSSEF is increased by $68 million, and the Prevention Fund request is increased by $78 million. CDC's total budget request is $222 million lower than FY 2012.

Discussion

Dr. Farley asked whether there is precedent for significant cuts to CDC in the President's budget and wondered whether there is an expectation that the funds will be restored by Congress.

Ms. Berger replied that the Prevention Fund dollars give the impression that funding is relatively level for CDC. In the eyes of many, money is money regardless of its source.

Ms. Rosenbaum said that the same situation applies to community health centers. The centers have a fund, and the agreement reached for the appropriation action for FY 2011 reduced them by $600 million by the same logic that the base funding can be reduced because of the Prevention Fund. The centers have been successful in quantifying their services and lives saved by their services, and lives that would be lost without them. She wondered if CDC can be as specific about the potential lives lost as a result of a reduced budget. Clinics can count patients and locations, but there could be some way for CDC to make a similar appeal.

Ms. Berger said that CDC struggles with articulating the impact/good work the agency does. The majority of CDC funds go to state and local health departments, and those

entities can help articulate what they may lose. It would be helpful, for instance, if the states articulate what they lost with the cut of the block grant in FY 2011.

Dr. Greenberg asked whether PEPFAR funds were reflected in the CDC budget, and Ms. Berger replied that they were not.

Dr. Greenberg commented that a flatline budget amounts to a decrease. Ms. Berger agreed with that statement in concept. Until last year, CDC was expected to account for a 4% cost-of-living adjustment in its salaries. Pay for most CDC personnel has been frozen, but other inflation issues affect their budget.

Dr. Greenberg said that CDC leadership can ask itself what it can do better to prevent these cuts from occurring, if the cuts are not occurring at all agencies.

Ms. Berger commented that CDC works through processes and systems in HHS, OMB, and the White House. People make decisions about priorities every day.

Dr. Farley clarified that the President's Budget for FY 2013 cuts CDC's budget by 22%. Ms. Berger agreed and added that the cuts represent a $1.5 billion reduction from FY 2010, before the Prevention Fund was used to offset CDC's basic programs.

Ms. Berger explained sequestration. OMB will decide when sequestration will begin. CDC is assuming that every federal agency will receive proportional cuts to its discretionary, non-security budget. CDC expects an approximate 9% cut to the FY 2012 base, which is approximately $500 million. It is yet to be determined whether CDC will have the discretion to make the cuts internally, or whether CDC will receive instructions regarding where the cuts should take place. The agency is planning for the worst-case scenario that funding for all programs will be reduced equally. CDC's mandatory funding will be treated differently. For instance, Vaccines for Children (VFC) will be held harmless because of its connections to Medicaid. Other mandatory problems are likely to be cut by approximately 2%.

Ms. Rosenbaum clarified that sequestration happens because of the budget that was made in 2011 that requires across-the-board cuts.

Ms. Berger expects that Congress will take action and not allow sequestration to happen, so it is likely that FY 2013 will begin under a Continuing Resolution (CR), perhaps with targeted cuts.

Dr. Greenberg asked whether the cuts affect the salaries of people who work at CDC and/or the number of people that CDC employs.

Ms. Berger replied that if the agency faces a cut, they will have to consider where to take those cuts. Ms. Villar added that the cuts could potentially affect salaries and the number of people who CDC employs.

Ms. Berger said that CDC does not have the authority to enact a reduction in force. CDC works with a number of contractors, and their first step would likely be to examine the contract workforce carefully. She said that fiscal oversight is a high priority across the federal government, and they all must be careful about how they are spending taxpayer dollars. A lot of CDC's work in public health education may not be perceived as such by

others. Some expenses, such as purchase of promotional items, may be perceived as frivolous. CDC has to consider carefully the conferences that it supports and the materials and documents that it buys. For instance, even a lighthearted reference to "free popcorn" gives her pause, as she is concerned about perceptions of how taxpayer dollars are spent.

Ms. Villar added that travel and conference attendance that CDC feels is necessary for what they do may be examined.

Dr. Isham said that one of the STLT Workgroup's priorities was achieving more funding flexibility for health departments and observed that the environment appears to be moving in the opposite direction. He wondered whether the changes are affecting or impairing CDC's overall ability to function.

Ms. Berger said that CDC's new budget structure mirrors NIH's budget structure, and NIH has been successful with that structure. The new structure poses immediate challenges for CDC. Under the new structure, dollars are appropriated for a topic, such as environmental health. If another program implements a program that utilizes environmental health, those funds can be used for that program because they are serving the original intent of the appropriation. The new structure is not overly constricting, and CDC can still consider collapsing lines to improve efficiency or provide more flexibility so that states can provide funding where they need it. CDC is working with its legal team to better understand how to navigate aspects of the new structure.

Mr. Climan hoped that humor would not be written out of everything.

Dr. Richardson asked for elaboration on the issue of fiscal oversight, adding that the ways in which fiscal scrutiny is applied could stifle innovation. Activities that could be perceived by others as frivolous are often activities that are non-traditional and not standardized. For instance, some successful interventions in the area of disparities could appear frivolous to those who do not understand the work.

Ms. Berger said that no policies have been set that would lead CDC to operate differently, but the agency is evaluating each case individually. For example, CDC might previously have purchased tote bags for a conference, but may not make that purchase now. If there is a public health need for something, then it can be supported.

Dr. Richardson said that it is not possible to gather evidence for effectiveness without trying things that have no proven effectiveness. She observed that the ability to identify new strategies and new approaches could be stifled if all activities are held to an evidentiary standard.

Dr. Farley clarified that approximately 60% of CDC's budget is allocated to state and local governments.

Ms. Berger offered to share a Power Point that explains the federal appropriations process to the ACD and answer their questions.

Dr. Sanchez asked whether the question-and-answer session could be conducted in an informal manner, such as a teleconference or a Webinar that would be open to ACD

members, but that would not require a quorum. He recalled teleconferences that had to stop when a quorum was lost, and he hoped to avoid that situation.

Dr. Fleming recognized that their conversations were focused on FY 2013 and asked about FY 2014. Some CDC programs and funds are in places where they support or provide clinical services to populations that will be covered by insurance in 2014. He asked about CDC's approach to this significant change.

Ms. Berger answered that CDC welcomes advice on this topic. She expected that the budget submission for FY 2014 would reflect some of those changes. For example, there is an expectation that because a percentage of Americans will be covered by insurance who were not covered before, some programs, such as breast and cervical cancer screening programs, will need less funding. CDC is conducting a scan of its programs that are directly impacted by this change. Programs that are particularly affected include chronic disease; breast and cervical cancer screening; and some areas within the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), such as TB and HIV screening. The Office of the Director is working with the programs to articulate the impact of the changes, whether the same level of funding will be needed, and where the funding should be redirected. She asked that ACD share any ideas regarding this articulation, economic data that are already available, and how to demonstrate the needs around these issues. There will still be needs during the transition period. CDC conducts a great deal of education and outreach, and they need to better articulate the importance of encouraging people to get screening, even if CDC is not the entity conducting the screening.

Ms. Rosenbaum urged CDC to evaluate the "naturally-unfolding experiment" in Massachusetts where health reform has been underway for a number of years. The continuing needs for direct funding for preventive services are enormous in Massachusetts. The needs exist for a number of reasons, and undocumented people are only one of the reasons. The most significant reason for the need for preventive services funding is breaks in coverage because coverage is intermittent. Out-of-network care is another problem in Massachusetts. People who are newly insured are not familiar with using health insurance, and so they utilize pharmacies that are not in the network, for instance. Newly-insured people may not understand networks. Many services have cost-sharing that nobody can pay. She encouraged CDC to commission a rapid analysis of a state such as Massachusetts from the perspectives of clinical preventives services, state and local health departments, and community health centers. The uncompensated costs to community health centers for ambulatory primary care will be informative. Texas presents another learning opportunity for CDC. When the family planning programs in Texas were lost, it was assumed that the Medicaid expansion coverage would be sufficient to fill the gaps. The family planning grant funds were funding access points that third-party reimbursers did not pay.

Dr. Richardson agreed and added that the issue of access to services is larger than just insurance coverage. It is naïve to think that a dollar-for-dollar or a body-for-body translation will take place. For instance, communities may have a lack of capacity. The issues are complex, and she agreed that CDC could collect evidence to counter the perception that public health will require less funding because more people have insurance. Research literature has examined how covered populations in Medicaid have their access "turned on and off" as they "turn on and off the program."

Dr. Sanchez indicated that Ms. Villar and the CDC staff would explore the possibility of ACD spending more time on a more in-depth overview of the CDC budget and its process. He observed that the ACD meetings are already time-constrained and full of information and suggested that they consider ways to offload information that may not be needed by everyone in order to allow ample time for other issues.

Health Disparities Subcommittee Update and Discussion

Dr. Sanchez explained that the Health Disparities Subcommittee to the ACD provides counsel to the CDC Director on CDC's efforts to address health equity, particularly in achieving the agency's priorities for reducing or eliminating health disparities. HDS was formed to provide high-level input to advance science, practice, and performance to eliminate health disparities and to achieve health equity. Specifically, HDS supports the development of CDC's objectives, priorities, performance indicators, activities, and initiatives to address health equity. HDS also provides guidance on opportunities for CDC to work with other sectors in partnership.

A group from the IOM presented on the IOM Roundtable for the Promotion of Health Equity and the Elimination of Health Disparities. The Roundtable took on 4 challenges: 1) to promote dialogue on the topic of health disparities; 2) to track promising activities and developments in the promotion of health equity; 3) to foster the emergence of leadership in the area of health equity; and 4) to convene a workshop on *Challenges and Successes in Reducing Health Disparities*. Dr. Sanchez offered to make the Roundtable presentation available to ACD. The presentation includes a timeline, accomplishments, and goals of the Roundtable.

HDS met on April 19, 2012, to discuss recommendations regarding how to close the gap in health disparities in the US. HDS members discussed several areas in which CDC could play a role in reducing health disparities: 1) framing health equity; 2) developing clear ways to communicate about the notion of health equity; 3) making the link to social determinants of health; 4) distinguishing social determinants of health from how they affect health, and health equity from health disparities. Health disparities are a problem to be addressed, and health equity is the goal. The two are not the positive and negative of one another.

HDS discussed the notion of funding health equity and recognizing the barriers to competing successfully for CDC funding. Too often, the communities with the most need have the least capacity to write a grant and create a plan. This problem must be addressed in order to achieve health equity across the US. CDC can examine how funding is received across populations, geography, and level of capacity, avoiding over-funding in certain areas as compared to other areas. HDS suggested that CDC build capacity for health equity, examining internal and external opportunities for how CDC can provide technical assistance and help the communities that are interested in doing work.

HDS suggested that CDC develop indicators for health equity that are both high-impact and feasible. Additionally, HDS discussed evaluating health equity interventions. Relationships with academic health centers and PRCs were mentioned in this conversation. The capacity, competency, and skill to do good evaluation do not typically exist at the local level. Building capacity to better understand resources at the local level to complete evaluations will be important. Grantees may not have to conduct the evaluations themselves, but can understand what good evaluation is and partner with other organizations that have the skill set to complete organizations.

The discussion points will frame a set of recommendations that HDS will formally submit to ACD. Dr. Will Ross, a member of HDS, will work with HDS members and the Office of Minority Health and Health Equity (OMHHE) to facilitate that process. HDS needs a new chair and three new members to replace members who have completed their years of service.

Discussion Points

Ms. Villar noted that Dr. Leandris Liburd, Director, OMHHE was unable to attend the ACD meeting as she had been called to a meeting at the HHS Secretary's office. She has been engaged with the HDS. She commented that HRSA has revamped their webpage and made funding opportunities front and center, with basic tutorials and videos from high-level staff within the organization. CDC will consider the HRSA website as they strive to make their information more accessible.

Dr. Richardson volunteered to join HDS and commented that the subcommittee faces monumental issues. She suggested that their deliberations "start close to the bottom," as public health should strive to provide data on the local level. Achieving health equity will begin with assessing the current state and tracking progress. CDC could identify existing data sources and move that discussion forward.

Dr. Botchwey added that the HDS discussion addressed the need to establish evidence at the local level. Evidence that is published is not from that geographic scale.

Mr. Climan suggested that HDS consider how technology will increase health disparities. The healthcare system will increasingly connect to the community via devices, so technology will play a role in how communities connect to the system.

Dr. Richardson added that technology can also help with the problem of health disparities. HIEs bring the opportunity to look at information at the local level.

Dr. Bal said that the metrics are not there, but CDC's work is required to be evidence-based. He described the conundrum in which local data is not available, especially for ethnic groups, and there are issues with the confidence limit. He recalled an example of an "out of the box" intervention that was almost not implemented, but was proved to be effective after the fact.

Dr. Sanchez suggested that proxies could be available for some of HDS's priorities. For instance, the Texas Diabetes Council has good data on the prevalence of diabetes and has projected the burden of disease into the future. The extent to which data can be discovered and the case can be made for the need for more granularity will determine whether they can move in the directions in which they want to move. Part of the work will include a gap analysis. Work has been conducted by the Agency for Healthcare Research and Quality (AHRQ), which can be packaged with other data that can suggest both activity and the need for more granularity and better understanding. The Center for Medicare and Medicaid Services (CMS) will need to understand these issues more. Health plans in the private world that expect to work in Medicaid managed care when it expands to include more adults than it has in the past will "hit a wall" when they realize that their strategies for medical management will not work the same in those populations. They will need to think through what the data shows, and whether Zip code-based strategies are needed as opposed to disease diagnosis strategies, or a combination of the two.

Ms. Kelly suggested expanding the reach of CDC partnerships to pharmacists at the community and state level. The community pharmacy is another mechanism that shares goals with CDC. Moreover, health is good business. Community pharmacists are often locally-based and knowledgeable about the community. Their voices are well-respected and trusted. They are accessible and could help amplify the message of CDC and local public health.

Dr. Iton volunteered to join HDS and indicated that he would reserve his comments for the subcommittee.

Dr. Greenberg recalled that large pharmacies were included as part of the rollout of CDC's Million Hearts Campaign.

Dr. Sanchez added that pharmacies can be good partners in global health, and can be part of any strategy pertaining to the STLT work. Pharmacies also represent a "not-usual suspect" that can help develop the services that public health should deliver. They are also a place where CDC messaging can be delivered to a receptive audience. He agreed that pharmacies are potential partners in health disparities work, as pharmacies are located in communities where there are tremendous needs.

Ethics Subcommittee Update and Discussion

Ruth Gaare Bernheim, JD, MPH (Chair, Department of Public Health Sciences, School of Medicine; Associate Director, Institute for Practical Ethics and Public Life; University of Virginia) Ethics Subcommittee Chair, described the current activities of the Ethics Subcommittee. She thanked Ms. Rosenbaum and Dr. Isham for their active participation on the Subcommittee and acknowledged Dr. Drue Barrett, the Subcommittee Designated Federal Officer (DFO).

Ms. Bernheim recalled that Dr. Frieden emphasized not only the evidence and data of public health, but also to understand and address the values underlying public health. Further, it is important to utilize strategies that "put a face" on those ethical values. These values are imbedded in public health, if they are not always obvious. The CDC anti-tobacco campaign is an example of these values. For years, a tobacco company distributed scrolls of the Declaration of Independence. CDC's message ends with the woman saying, "Enjoy your independence." It is important to understand, acknowledge, and address that there are values imbedded on both sides of these issues.

The Ethics Subcommittee is engaged in assessing the needs of state and local health departments. The Subcommittee is developing tools and partnerships to address these needs, which include case studies and training efforts that are ongoing with the National Association of County and City Health Officials (NACCHO). Further, the Subcommittee is evaluating the impact of public health ethics. To assess the needs of state and local health department officials, the Subcommittee has held educational Webinars to share information about public health ethics. During the discussion after the presentation, the participants share their major ethical concerns. The Webinars have reached officials in 9 of the 10 public health regions. In addition, the Subcommittee has reached out to local and tribal health officials. The Webinars help people understand different sides of issues and how to frame their understanding.

Common public health issues that raise tensions include: 1) resource allocation; 2) negotiating the political context; 3) data use and management, including privacy and

confidentiality protection; 4) control of infectious diseases; 5) immigration; 6) community engagement; and 7) balancing individual choice with protecting the public good. The Ethics Subcommittee created specific cases based on these concerns. For instance, health communities around the country are grappling with how to frame justifications for restricting smoking in public spaces.

When local and state officials face ethical issues, they often consult their lawyers. Lawyers do not necessarily want to provide ethical advice, but when they are pressed, they often say "no" or "you can't." The public health officials expressed a need for more than, "you can't." Officials at the local and state level need capacity-building, education, training, and infrastructure to address the ethical tensions that they face every day. Resource allocation is a major issue in these times, and ethical discussions would be particularly useful in this area.

The local and state officials asked the Ethics Subcommittee to develop case studies and reference guides. They also asked that CDC create a repository for public health ethics information and cases, with tools. They indicated a desire for online public health ethics courses that are accessible to those outside CDC, as well as Webinars or other venues to continue discussing ethics issues. Ethics is part of public policy in the creation of forums where all stakeholders can present their positions. Without the capacity to hear and address those positions at the state and local level, it is not possible to incorporate ethics and values fully into public health practice.

The subcommittee has developed case studies in partnership with local and state health officers. The subcommittee is developing training manuals and has been invited to conduct training with health officials with NACCHO in July 2012; with the National Association of Local Boards of Health (NALBOH) in August 2012; at the Public Health Law Conference in October 2012; and with the American Public Health Association (APHA) in October 2012. The case studies from real-world practice form the foundation for the training materials. The subcommittee is exploring collaboration between public health law and public health ethics. They have been working with their colleagues at CDC and the Network for Public Health Law and recognize that law and ethics are complementary tools. The subcommittee is creating case studies with issues concerning both law and ethics. These cases will help the field tease the issues apart and quiet the lawyers so that it can move forward with new ideas. The subcommittee is also examining approaches for evaluating the impact of public health ethics.

Case studies are in progress on a number of issues, including treatment of multi-drug resistant TB, mandatory vaccination for health care workers, parental refusal of childhood vaccines, intimate partner violence screening, and PDMPs. The cases are grounded in real-practice situations.

Potential topics for new case studies include the Affordable Care Act requirements regarding community needs health assessment. Public health officials have been assessing community needs for some time. Public health understands the priorities of the community, but those priorities are not necessarily reflected in the priorities of the health system. Other potential topics include privacy and data confidentiality concerns, NCD topics, and winnable battle cases.

The NACCHO workshop is an experiential, capacity-building training. The format begins with didactic information and then moves to cases to give participants the capacity to train

people in their health departments to help them think through the ethical dimensions of various stakeholders.

The Ethics Subcommittee consulted with Dr. Monroe, OSTLTS Director. She validated the subcommittee's focus on the development of cases and felt that they would provide useful strategies for local and state officials. She suggested that cases should address "the news of the day" in terms of current ethical issues that health officials must address. She supported the subcommittee's ideas regarding coupling public health practitioners and academic ethicists, in a manner similar to the Public Health Law Program activities. Dr. Monroe also suggested that Webinars are a good approach for reaching out to state and local health directors and endorsed the notion of adding ethics to the next round of PHAB standards.

The Ethics Subcommittee has also worked with evaluation staff at CDC to create evaluation tools for public health ethics. They have created a logic model that begins with activities and infrastructure, and moves to outputs and outcomes. After working with state and local officials, at the end of the process, the subcommittee will have created measurable outcomes for ethics that can be communicated in terms of best practices for how to combine ethics and law in practice to provide a new capacity at the state and local level.

Ms. Bernheim described the Ethics Subcommittee's overall strategy regarding public health ethics. In moving from the knowledge, science, and evidence base that is necessary for public health, but often not sufficient, to translate into actions, the subcommittee has identified a gap regarding ethics and competing ethical values. The subcommittee's goal is to build capacity at the state and local level to address those tensions. She looked forward to ACD's comments and input.

Discussion Points

Dr. Sanchez thanked Ms. Bernheim, Dr. Barrett, Ms. Rosenbaum, and Dr. Isham. This work is critically important, and guidance for the officials on the front lines is needed and appreciated.

Ms. Drew Ivie was excited that the list of potential topics includes using Supplemental Nutrition Assistance Program (SNAP) vouchers to purchase sodas. She suggested that the subcommittee expand that idea. The dollar figures of profit to fast food chains from the use of food stamps indicate that it is big business. She has worked on this issue in Los Angeles. The local public health officials there say that there is no definition of healthy food, so they cannot get a list of contractors for food stamps without the risk of being sued for artificially limiting who can be in the program. She was particularly troubled by the Electronic Benefit Transfer (EBT) signs in the windows of fast food outlets. Everyone who receives food stamps is not eligible to use their card at fast food outlets, but for the populations who can use them, she is dismayed that taxpayer dollars are making them sicker by giving them access to that sort of food.

Dr. Farley liked the use of case studies to work through ethical problems. He commented that he and his colleagues encounter the ethical questions of how public health agencies should work with private sector entities on health issues. For example, they would be comfortable if hospitals provide funding to community groups for physical activity promotion; however, they would not be comfortable taking money from tobacco companies for any initiatives. Those examples represent two ends of the spectrum, and

cases in between are challenging. In some situations, McDonald's wants to provide funds to church groups to implement exercise programs for children. People will feel differently about these situations, and case studies will help people be aware of the issues.

Ms. Bernheim said that the subcommittee is developing a case that deals with partnership issues. In this era of prioritization and cutbacks, everyone is pressed to make new partnerships. Making safe partnerships for public health relies not only on avoiding the conflict of interest, but also on avoiding the perception of conflict of interest.

Dr. Sanchez noted a cross-cutting issue that applies to the work of the HDS. He knows people who serve on the boards and advisory committees of large corporations that are engaged in activities that public health may not condone, in terms of the products that they promote. Large, national, race/ethnicity-based organizations are accepting funds from beer and tobacco companies, and they are conflicted. It may be worth considering the ethical dilemmas that people who on the one hand advocate for improving the lot of those who are disproportionately disadvantaged, and at the same time live off of resources from organizations that some might say are contributing to those disadvantages. These conflicts merge ethics issues with health disparities issues.

Dr. Bal said that the issue is an "innocence by association industry strategy." The tobacco industry used to fund the American Women's Medical Association and Hispanic and African American groups. The beverage industry is employing the same strategy. At the local level, money is money. Local organizations and entities are facing financial challenges, and these groups are supporting issues such as the homeless and nursing home care. He was not sure how to handle these issues. Public health cannot fund everything, and the needs are great. He commented that these issues are cutting-edge, and he suggested that CDC spread the word about the case studies, when they are complete.

Dr. Palacio pointed out that NCD work presents an intersection between ethics and health equity. CDC has an opportunity to provide guidance regarding the unintended consequences of public health's work. For instance, policies aimed at the built environment could look like gentrification to another group. Other policy interventions may benefit the community as a whole at the expense of some communities. The built environment improvements have market consequences that can cause displacement of disadvantaged communities.

Ms. Bernheim said that state and local officials need capacity and space to think about policies, benefits, and burdens that are borne by different groups. Are the policies for individuals, the population, the short-term, or the long-term? Officials need ways to measure and explain the policies. Public health can draw on the foundation of ethics as they take all stakeholder values and claims into consideration, hear all of the voices, and explain why a certain policy is pursued. The case studies can serve as training tools and infrastructure to provide a language and a process for that work. The Ethics Subcommittee believes that when capacity is built, it will be possible to measure outcomes in terms of effectiveness.

Dr. Richardson stressed that the work of the Ethics Subcommittee is very important. She observed that the US lacks the kind of robust ethical infrastructure that many European countries have. Perhaps CDC should fund ethicists to work on these issues that have been raised, and get involved in these issues beyond educational efforts and case

studies. She suggested funding philosophers, lawyers, and policy experts to consider these difficult issues and craft real solutions and resolutions.

Ms. Bernheim said that the Ethics Subcommittee attempts to fill that gap. The subcommittee addressed ethical issues associated with ventilator allocation in an emergency and created a policy paper. The subcommittee heard feedback that a policy paper may be less useful to the field than real-world, cutting edge cases that state and local health department officials can use to build their capacity. She agreed with the need for an ethical framework, such as the framework created by the Nuffield Council, to help address dilemmas in practice and policy formation. Such a frame would include language and tools to illustrate trade-offs, measure them, and give stakeholders a forum to express their views.

Dr. Richardson clarified that her suggestion was to fund the work beyond what "talented and dedicated people can do in their spare time."

Dr. Frieden highlighted a disturbing issue in public health. In practice, public health practitioners conduct surveys of people, discover that the people are doing things that may kill them, and then leave. Because the surveys are anonymous, it would be challenging to do anything additional, but the issue is troubling.

Ms. Bernheim said that local and state officials are asking about their essential role, as well as their essential services. The local and state officials serve as conveners, coordinators, negotiators, and in many other functions. Sometimes, public health is also the "physician of the community." She thanked ACD for the opportunity to speak and welcomed additional input and comments.

Presentation of Letters of Service to ACD Members Whose Terms End on June 30, 2012

Dr. Frieden thanked Dr. Sanchez, Mr. Climan, Ms. Kelly, Dr. Jack Lord, and Dr. Suzanne Delbanco for their service to the ACD. He said that he values the input of ACD as well as their insights, leadership, and willingness to continue serving on critical ACD subcommittees. He presented each of them with a certificate and a pen.

Ms. Kelly said that it had been an honor to work with ACD. She works in the private sector and indicated her appreciation for the commitment and dedication of CDC.
Mr. Climan commented on CDC's relevance and clarity, the manner in which tasks are being attacked, and his sense that the tasks are being accomplished by skilled people who dedicate themselves to critical work. The work is becoming more important, with fewer resources. He has hope that the US can reverse its health trends.

Dr. Sanchez said that the degree to which it appeared that he knew what he was doing at any given time was because of the work of Ms. Gayle Hickman and her team. He thanked Ms. Villar, Dr. Frieden, and the CDC Foundation. CDC is comprised of people who are smart and dedicated, and the agency is entirely mission-driven. It is never about dollars in public health. It is about the imperative of health. He thanked CDC for its work to make difference in the US, in other countries, and in our neighborhoods and states.

Discussion Points

Dr. Frieden said that during the H1N1 situation, CDC immunization staff were imbedded in 42 out of the 50 states. The concept of imbedding CDC staff at state and local health departments is important, and the practice should continue. Immunization has been at the intersection of public health and clinical medicine for some time. Everyone in the healthcare system views children's immunization records, for instance, and uses opportunities to update immunizations. Clinicians could do the same thing with blood pressure and other preventive services. In many ways, immunization has best practices to share with the rest of public health.

Dr. Fleming agreed and noted that immunization is an example of a traditional public health program that focused on direct delivery of service is rapidly changing. He asked ACD to share ideas on how to make that transition.

Dr. Isham commented that the more complex the immunization regimens get, the more challenging they are to carry out. Both public and private delivery systems are faced with these challenges. Progress has been made in the interface between databases, which presents opportunities. Another challenge is the technical issue of anticipating a population's needs. Process and design issues concerning care at the point of care, whether in a public or private setting, include designing work flows and assigning roles for delivery and allocation are all systems questions that transcend the approach that focuses on the maximum effort of individuals.

Dr. Schuchat agreed that the modernization of system is exciting and presents opportunities. Since ARRA and the Prevention and Public Health Fund have provided resources, NCIRD has focused investments in IT modernization. For instance, the registries of immunization information are being connected with EMRs. CMS has provided incentives for providers to update their EMRs. NCIRD is also working to standardize the way that immunization information flows from the registry and back. NCIRD has also modernized and upgraded the IT system that runs the supply chain for the 80 million doses in the VFC program. A bar code project aims to include the information on vaccine vials into the EMR, which will complete the information for the office and the registries. Investing resources into IT now will make their work easier to sustain through budget challenges. Systems issues have been a strength of immunization. The registries were critical for reminders, recalls, and raising coverage. They also provide feedback. The permutations and combinations of vaccines are enormous, and the supply situation is ever-changing, which presents challenges to providers and families. A Georgia Tech student developed an electronic scheduler to help people know what vaccinations they are due to receive. Unfortunately, the 49 state registries are all different, and they need Memoranda of Understanding (MOUs) to be able to share data.

Dr. Bal said that if the Chronic Disease Center were given $4 billion, the center would "take the world by storm." Dr. Frieden reiterated that VFC is mandatory funding.

Dr. Palacio raised the issue of the transition to a medical home. The shift to integrated care makes sense, but there are budgetary impacts to consider. As a local health director, she is concerned about losing infrastructure around public health preparedness efforts. The concept of dual use is being lost. It may make sense to lose some immunizers on a day-to-day, routine basis, but the field is also losing immunizers who are trained and skilled in emergency response. Mass vaccinations, especially in a time-

pressured environment, require a different skill set. In an emergency, the healthcare infrastructure will already be overloaded. Even if the providers could be brought from the infrastructure to focus on immunizations, funds might not be available for them. She asked about opportunities for CDC guidance to state and local officials regarding managing the interface with a shrinking infrastructure, or models of scopes of practice. For instance, dentists could be brought as partners.

Dr. Farley said that the New York City electronic immunization registry is strong, and they are building bidirectional communication with EHRs across the city. Providers are asking for those connections. Families and providers want up-to-date information about immunizations that were given elsewhere, so the children are not immunized again. The registry has been so successful that it has been proposed that it should include newborn hearing screening and other activities. Bidirectional immunization registries are critically important and are key to immunization coverage. The registries could serve as a model for other ways for public health and healthcare to interact.

Ms. Kelly said that immunizations are most relevant in the fall, because records are created and given to schools when children return to class. It would be helpful to provide support for families in this process. The language can be confusing to non-clinicians, and access to providers can be challenging, so families often bring immunization forms to their pharmacists. Educating pharmacists might be a useful way to remind people about immunization. Pharmacists have regular contact with populations and could serve as an access point for information and keeping immunizations and boosters up to date.

Dr. Frieden asked how the immunization registry can serve as a model. It could serve as a model for other areas of public health, such as cancer or HIV screening. It could also serve as a model for other areas that relate to HIE. Immunization registries are population-based, as they are populated by birth certificates and other sources of information. This approach is unique in public health.

Dr. Farley noted that patients move from one provider to another, and providers value the data that comes from the patients' records. If public health can facilitate that sharing, then public health becomes valuable to the healthcare system in a new way.

Dr. Frieden added that patients own that information, and they want it to be shared with their current provider.

Dr. Sanchez added that this work is also a way to indicate that public health is relevant to ACOs and HIEs. Public health must be made relevant to the world of clinical medicine, or it will continue to be ignored. Immunization is an example of how public health is a relevant piece of a broader system.

Dr. Schuchat agreed with the concerns regarding preparedness and the ability to conduct mass campaigns. NCIRD's next 5-year grant announcement includes the preparedness function of the immunization program. In some states, the preparedness grants and the immunization grants were so separate that the programs did not realize they had a common mission. Regarding back-to-school information, mothers' needs, and pharmacist partners, she said that CDC has strong partnerships with pharmacies. One of their objectives is to secure designations for pharmacies as in-network providers. Pharmacies can fill a major gap, especially for adults and teens who may not have a regular provider. Pharmacies can also participate in the immunization registry. NCIRD has updated its

website so that the parent portal includes relevant information that is easy to reach. Most registries can be accessed by providers to determine the immunizations that a patient has had.

Dr. Isham said that private systems with private medical records already have this functionality. Their challenge concerns standardization and linkage to registries, as opposed to competing requirements. The applications and vendors for EMRs are not standard and do not use the same functionality. There are opportunities to encourage standardization of key elements for public health as well as clinical participation in public health activities.

Discussion of Cross-Cutting Issues: Improving Collaboration with STLT Health Departments

Dr. Fleming introduced the next session, in which ACD members were asked to provide advice regarding cross-cutting issues at CDC. The leaders of programs at CDC that fund public health agencies the most were present to hear the discussion.

National Center for Immunization and Respiratory Diseases

Anne Schuchat, MD (Director, National Center for Immunization and Respiratory Diseases, CDC) explained that the National Center for Immunization and Respiratory Diseases (NCIRD) is the steward for the VFC program, a $4 billion entitlement for children who are uninsured and other vulnerable children. NCIRD also supports the Section 317 state and local immunization grants. She often hears questions regarding whether state and local health departments are now irrelevant, and whether the Section 317 program is no longer needed because of coverage under ACA.

Twenty-five years ago, most immunizations were administered by state and local health department staff. More than 80% of vaccines are now administered by the private sector, and more than 90% of vaccines are administered by a VFC provider who mainly serves privately-insured people. However, 25 years ago, fewer vaccines were recommended. Today, 16 diseases are vaccine-preventable for children. Very few providers and parents have actually seen the diseases that these vaccines prevent. Leadership is needed to support providers and families as they navigate the complexity of immunization. State and local health departments have a major stewardship role in understanding the gaps in clinician knowledge and in building that knowledge and capacity. The VFC program sends staff into doctors' offices to visit, conduct coverage assessments, and to evaluate vaccine storage and handling. Costs of vaccines have increased, and the volume of vaccines stored at offices has also increased, leading to concerns regarding storage and handling. Additionally, families are having more questions regarding the vaccines. Clinicians are spending a great deal of time meeting those needs. State and local health departments can serve as a bridge between the clinicians' needs and the community concerns.

NCIRD has focused on improving conversations that take place in providers' offices and on installing leaders and champions in the states that can support clinicians in this difficult task, and in assuring the strength of the laboratory and epidemiology tracking of diseases. VFC is under scrutiny, and CDC plays a significant role in accountability and credibility, ensuring that the funds and the vaccine doses are going to populations where they are needed and are being used appropriately.

With National Immunization Week and Global Immunization Week coinciding, the connections between the global and US situations are apparent. NCIRD would like to be more supportive of state and local officials, knowing that their resources are very tight.

HIV, Hepatitis, STD, and TB Prevention Center

Kevin Fenton reported that the HIV, Hepatitis, STD, and TB Prevention Center (NCHHSTP) is large and complex. It deals with sensitive issues and prevalent conditions. The conditions that NCHHSTP addresses are highly prevalent, but they are not randomly distributed in the population. They disproportionately affect populations that are socioeconomically marginalized, racial and ethnic minorities, and populations with poor access to curative services. The center has observed evolutions in the epidemic and local-level challenges in the response to the epidemic due to the economic downturn; disinvestment in prevention; disinvestment in staffing capacity at the local level, which has a negative impact on the ability of state and local jurisdictions to respond effectively. New national strategies guide efforts at the national level, and public health is moving in new directions of prevention through the NHAS and the Viral Hepatitis Action Plan, which was developed across HHS and with White House partners.

Given the challenges, NCHHSTP has changed the way that they approach prevention. Kay characteristics of these changes include the realignment of resources to meet today's epidemics. Funding distributions are based on today's epidemiology and ensure that the resources meet needs at the local level. NCHHSTP is strengthening its focus on guiding state and local health departments to target interventions to populations with greatest need and to bring the most effective interventions to appropriate coverage and scale within the population to achieve the greatest public health impact. That approach is applied to all of the infectious diseases addressed at the center. The center works with state and local health departments to focus on key best practices in public health to support the response to infectious diseases. These approaches include focusing on collaboration and integration, considering the clusters of infectious diseases as endemics and breaking down the barriers between the responses to HIV, STD, TB, and viral hepatitis. The center also encourages greater focus on health equity issues and holding state and local health departments accountable for addressing social and structural determinants of health. NCHHSTP also encourages grantees to explore new partnerships in prevention.

The center is grappling with key issues in workforce, accountability, and credibility. Tremendous challenges face the workforce at the state, local, and community levels as dealt departments are required to downsize or furlough staff. Additionally, it is challenging to ensure that an appropriate cadre of public health workers is available who understand the needs for responding to the epidemics. The skills mix at the local level may not include the optimal distribution of economists, sociologists, and ethicists to help public health respond appropriately. As ACA places focus on prevention through healthcare, public health must scale up its workforce to bridge the gap between traditional public health and clinical services.

Public health workers at the local level need to be accountable. Treatment is prevention for all infectious diseases. Accountability is particularly important in HIV. Public health departments must work with local public health partners to focus on accountability for treatment and ensuring quality improvement for treatment for infectious diseases. As epidemics evolve and present new challenges, it will be important for public health partners to communicate the evolutions effectively. Public health partners must serve as

effective champions for the diseases and as credible partners as voices for advocating for the infectious diseases. Additionally, partners must advocate with clinical partners and those outside of health to ensure effective response to the infectious diseases.

National Center for Chronic Disease Prevention and Health Promotion
Ursula Bauer reported that the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) addresses a range of chronic diseases and risk factors. The center focuses on transforming communities and the way that states and communities address health. The center works across sectors, changing physical and social environments to promote health.

As the center has focused on these transformations, it has not transformed itself. The center has not changed the way that it deploys its chronic disease prevention and health promotion programs or the way the center partners, primarily state health departments, do that work. NCCDPHP is very siloed in specific programs, diseases, and risk factors. This structure poses a number of challenges for the center and for state health departments because of inefficiencies and a lack of a critical mass of resources to address the programs that they are charged with addressing.

The changing context has brought new emphasis on outcomes and return on investment. NCCDPHP considers how they and their state health department partners deploy programs and how to gain efficiencies to be more effective in achieving disease- and risk-factor-specific outcomes as well as overarching outcomes, such as quality of life, life expectancy, and reduced use of healthcare. The center has homed in on four domains that are cross-cutting and will simultaneously address and improve outcomes for the range of chronic diseases and risk factors:

- Epidemiology and surveillance
- Environmental approaches that change context to support healthful behaviors
- Working with health systems via a comprehensive approach across the center's programs to improve effective delivery of quality clinical and other preventive services, as well as to reach into the population to build demand for those services
- Linkages between clinic and community: The center has worked in this area regarding promoting chronic disease self-management, diabetes primary prevention, but has not been able to achieve a critical mass of resources and focus in those areas, so few communities and individuals are supported in changing the behaviors that affect the diseases and conditions that the center addresses

NCCDPHP has identified a number of gaps within its center and gaps at their state partners. Working with healthcare systems is a key gap in the center's knowledge and in state health departments. The center is considering how to make a place for themselves in the new environment. What is the center's role, for example, in hospital community benefit distributions? How should the center work with ACOs? How can the center ensure outcomes in population health? The center has identified gaps in their ability to stimulate linkages between the clinic and the community and to stimulate community support to deliver crucial, structured lifestyle programs that give people with, or at high risk for, chronic conditions the tools that they need to avert disease, delay the onset of complications, or mitigate their problems to improve their quality of life and reduce their need for healthcare.

Chronic conditions tend to cluster in the population and are not evenly distributed. The center is considering how to support communities and how to expand the reach and delivery of programs, given the current resource limitations. Another gap is working with employers and businesses to improve the health of their employees and galvanizing businesses to act in their own self-interest in supporting community health. Public health should be able to deliver a healthier workforce to employers, but businesses need to be advocates for that work and to demand that work from the public health system.

This work requires leadership and vision from the center as well as from their STLT partners. The work also addresses the issues of relevancy and credibility, and the role of state health departments in the new environment. The center is considering how to build critical mass in the four key areas that will "move the needle" on population health.

Discussion Points

Dr. Fleming thought that one of the exciting aspects of serving on the STLT Workgroup is the opportunity to experience the talent and passion at CDC. Although NCHHSTP and NCCDPHP address very different disease groupings, their challenges are similar, including workforce, improving partnerships, and working with the healthcare system.

Dr. Sanchez said that the challenges are concerning, and there is a place for CDC to do innovative work. For instance, in HIV and STDs, the changes in healthcare may not have considered what happens outside the clinical setting, which is as important as what happens in a provider's office. CDC thinks about the entire picture and can ultimately add value, helping organizations such as ACOs incorporate that thinking and become more successful. Working with partners who are connected to the clinical world, such as Dr. Isham, Dr. Chu, and himself, will help create spaces to have those important conversations. He expressed concern with the belief that prevention and health can all be transferred to clinical practice. For instance, it is not well-understood that people with insurance who have STDs go to STD clinics in their communities because they desire anonymity. An important ethical conversation should be conducted regarding how to create safe, anonymous spaces so that people can get the care that they need in a way that protects them. The chronic disease world also may not embrace what has been learned in the HIV/STD world. If the patient is the center of the universe, then the care should be "patient-centered, community-integrated" to recognize that people live their lives in communities. For instance, work in the built environment is not based on the notion that "food deserts" cause obesity; rather, the work is based on the notion that everyone deserves the right and expectation to have access to affordable, good food. The chronic disease world is beginning to understand that the ellipse of the medical care system on the Wagner's model is too big. The ellipse should be smaller and recognize that community-based initiatives will make a difference. CDC and its partners can make the case that in order to achieve positive health outcomes and lower costs, the quality equation must include what has been called "public health" in the past. Public health is a part of the health system. He thanked Drs. Bauer, Fenton, and Suchuat for their work.

Dr. Greenberg referred to the reapportionment of CDC's HIV/AIDS prevention funding. It is sensible to put resources where the epidemic is, although there are "8 winners and 42 losers" as a result of this important decision. He asked about the potential argument that CDC is punishing groups that have been successful at prevention and about valuable lessons that NCHHSTP has learned from its interactions with health departments on this issue.

Dr. Fenton said that NCHHSTP had learned valuable lessons on the tough journey. Resistance naturally accompanies major change, and the center has worked with state and local partners to bring them along on the journey. The NHAS made it clear that the funding inequities in the US could not continue. When the strategy was released in 2010, NCHHSTP had the opportunity to change its funding allocation with the new HIV prevention FOA. The center is committed to doing this work for all of the infectious diseases that it addresses. Some funding realignment has begun in the STD and TB programs. The rate of change for those programs has been slower than the rate of change for HIV. The changes come with accountability for those who are gaining resources. CDC is being far more proscriptive now than ever with the HIV prevention program, clearly stating the interventions that are expected to be targeted and scaled up, holding jurisdictions accountable. Capacity-building and technical assistance support from the center will help the jurisdictions that lost transition to lower levels of funding by asking them to focus on the most impactful interventions.

Dr. Bauer said that CDC has two roles, which are often in conflict with each other. As a federal agency, CDC's special relationship to state health departments includes building capacity, infrastructure, and expertise. However, CDC is also the nation's prevention and public health agency and has a responsibility to bring down national trend lines. CDC will not successfully bring those lines down with a 50-state strategy. They have not made the case strongly enough for CDC's role in addressing national trends.

Dr. Frieden observed an analogy with CDC's global work, pointing out that working in Nigeria or India requires a different level of response than working in a country with 2 or 3 million people. He agreed that CDC may suffer from a "one size fits all" approach. Focusing on where the problems are most acute is important, even if the approach is not always politically wise.

Dr. Farley said that CDC has been organized by disease type for a long time. Almost all of those diseases interface with the healthcare system at some point, but CDC has not been strong in its interface with the healthcare system. The New York City health department reorganized so that their healthcare-related work, including diabetes, hypertension, and general quality improvement, are all located within one division. The division that previously focused on chronic prevention is now focused on community prevention, including behavior change and environmental approaches. This structure gives the department the opportunity to change the healthcare system. He encouraged CDC to think about a similar approach, building a unit devoted to interfacing with the healthcare system. That unit can work across centers. The healthcare system does a poor job of STD care, yet most STDs are treated in the healthcare system. The STD division will not have the capacity to change that dynamic, but a healthcare systems division could.

Dr. Frieden said that the question was debated as part of the OI change at CDC. They created an Office of Prevention Through Healthcare, which is headed by Dr. Chesley Richards, within the Policy Office. Ultimately, a larger unit should focus on these issues, and he was interested to learn about the experiences in New York.

Dr. Bauer said that NCCDPHP has reorganized to some degree. They have not reorganized according to the four domains she described. They have not ruled out that logical structure yet, but they are working on those domains across the four divisions so

that their efforts are unified. They are sharing resources and expertise to work in a more coordinated and comprehensive manner.

Dr. Fenton said that NCHHSTP has articulated prevention through healthcare as one of their overarching goals. The center has invested in new bodies at the center level and the division level to focus on this issue. NCHHSTP is building that expertise within the divisions and working across divisions in a networked fashion so that the center is moving in the right direction. They still maintain centers of excellence for prevention for infectious diseases, but are integrating the prevention through healthcare capacity in each division.

Dr. Isham agreed that expertise needs to be developed in the area of relationships with the healthcare delivery system. He recalled a meeting in January 2012 with national employers to learn how they felt that health relates to their business model and making money. The responses were interesting and can guide public health in helping employers become more interested in the determinants of health in communities. This approach, of helping a sector or potential partner fit prevention and health within their goals and activities, is not often seen in public health. Businesses are interested in where they locate their factories, for instance, and after 2014, they will be concerned with productivity in the workforce as well as benefits. There are opportunities for chronic disease prevention in healthy workforces, healthy communities and how they relate to economic viability, and other areas. Providers need to understand factors beyond the clinical realm that affect their ability to care for their chronic disease patients, such as education and transportation. Public health can articulate those factors and create a dialogue with clinical health. There are opportunities for toolkits or approaches for businesses, private health care, and other sectors.

Dr. Bauer concurred that business decisions, including where to locate, are incorporating the health of the population, the health of the workforce, the education of the population, and other factors. These factors are motivating to county executives and city leaders. Making the case that investing in prevention now will bring benefits in recruitment efforts will be a strong recruitment point.

Dr. Isham suggested that these factors would also stimulate community investment and bring local revenue for public health.

Dr. Bauer agreed, noting that community dollars are invested in tax breaks to lure businesses to an area, but a similar investment in health could go farther.

Dr. Fenton said that NCHHSTP has a long record of working in the business sector, in part because of efforts to scale up national HIV prevention approaches. Businesses want to do more for their employees who are disproportionately affected or who are at risk for the disease. Now, the center is asking the business center to help leverage private sector resources to help in the fight against HIV and infectious diseases. The center is engaged in new conversations about distributing diagnosis, linkage to care within communities, and the role that businesses can play in that work. He said that health equity issues are significant for NCHHSTP. Some of the most glaring inequalities emerge in the center's cluster of infectious diseases. The center has made addressing health equity a strategic priority. As ACD discusses health equity, he offered to share the center's work and new ways of thinking about health equity, and how CDC can help support states as they transition to thinking about health equity in new ways and to have accountability for addressing social and structural determinants that drive the epidemics.

Ms. Drew Ivie commented that the nonprofit infrastructure in Los Angeles County has been decimated in recent years. Changes at the national level cannot be effective without community partners. If local business is brought into the work, they could be asked to help develop, revive, or start new private agencies that will be in touch with the populations.

Public Comment

As Dr. Sanchez had departed the meeting, Ms. Villar opened the floor for public comment at 2:52 p.m. No public comment was offered.

Closing Comments

Dr. Frieden thanked the meeting participants for their time and commitment, noting that the ACD meetings are stimulating in a wide variety of areas. He thanked ACD members for their service and for continuing to provide great advice to CDC.

With no further business posed or additional comments or questions raised, the meeting officially adjourned at 2:53 p.m.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the April 26, 2012, meeting of the Advisory Committee to the Director, CDC are accurate and complete.

_____
Date

_____
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

Nisha D. Botchwey, PhD, MCRP, MPH
Associate Professor, Georgia Institute of Technology

Benjamin K. Chu, MD, MPH, MCAP (via telephone)
Group President, Kaiser Permanente Southern California and Hawaii
President, Permanente Southern California Region

Sanford R. Climan, MBA, MS
President
Entertainment Media Ventures, Inc.
Chair, Communications Workgroup

Sylvia Drew Ivie, JD
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, Trial, Local and Territorial Workgroup

Lynn R. Goldman, MD, MS, MPH
Dean, School of Public Health and Health Services
Professor of Environmental and Occupational Health
George Washington University

Alan E. Greenberg, MD, MPH
Professor and Chair
Department of Epidemiology and Biostatistics
George Washington University School of Public Health and Health Sciences
Chair, 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 (via telephone)
Senior Vice President, Healthy Communities
The California Endowment

Mary Kelly
Executive Vice President
Merchandising and Category Management
Shoppers Drug Mart

Herminia Palacio, MD, MPH
Executive Director
Harris County Public Health and Environmental Services

Lynne D. Richardson, MD, FACEP
Professor of Emergency Medicine
Professor 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
Chair, Policy Workgroup

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
Executive Director
American Public Health Association

Suzanne Frances Delbanco, PhD
Executive Director
Catalyst for Payment Reform

Jonathan (Jack) T. Lord, MD
Chief Innovation Officer and Professor of Pathology
Miller School of Medicine, University of Miami

CDC Staff Attending:

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Office of the Associate Director for Program

Annie Archbold, PhD, MS
Health Scientist
Office of the Associate Director for Program

Ileana Arias, PhD
Principal Deputy Director, CDC
Principal Deputy Administrator
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Office of the Chief Science Officer
Office of the Director
Designated Federal Officer, Ethics Subcommittee

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National Center for Chronic Disease Prevention and Health Promotion
Office of Noncommunicable Diseases, Injury and Environmental Health

Beth Bell, MD, MPH
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National Center for Emerging and Zoonotic Infectious Diseases
Office of Infectious Diseases

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Office of the Director, CDC

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Director, National Center for Immunization and Respiratory Diseases (NCIRD)
Office of Infectious Diseases

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CDC Deputy Director for Surveillance, Epidemiology, and Laboratory Services

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

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Associate Director, Institute for Practical Ethics and Public Life
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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 Officer
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 Workgroup
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	*Morbidity and Mortality Weekly Report*
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
RWJ	Robert Wood Johnson

Acronym	Expansion
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