Meeting of the Advisory Group on
Prevention, Health Promotion, and Integrative and Public Health
Second Meeting: May 24, 2011 (held via WebEx)
12:00 P.M. – 2:00 P.M. (EDT)

ATTENDEES

Advisory Group Members:

Jeffrey Levi (Chair), Judy Ann Bigby, Richard Binder, Ned Helms, Patrik Johansson, Charlotte Kerr, Vivek Murthy, Barbara Otto, Judith Palfrey, John Seffrin, Ellen Semonoff, Susan Swider, Sharon Van Horn

Unable to Participate:

Valerie Brown, Jonathan Fielding, Elizabeth Mayer-Davis. Linda Rosenstock

HHS Staff:

Regina Benjamin (Surgeon General), Corinne Graffunder (CDC's Office of the Associate Director for Policy and Designated Federal Officer (DFO) for the Advisory Group)

ACTION ITEMS AND NEXT STEPS

Advisory Group:

- E-mail ideas for the roll-out of the National Prevention Strategy directly to the HHS Office of External Affairs.
- Dr. Levi will ask Ms. Brown to revise her resolution to reflect the updated version of the National Prevention Strategy.
- Review the two working groups and volunteer to serve on one or both of them.
- The working groups and their initial, proposed charges are:
    - *Working group on Engagement*
      The charge will be to provide background information to the full Advisory Group to assist in identifying implementation steps associated with the National Prevention Strategy so as to assure a culture of wellness and prevention throughout the federal government.
    - *Working group on Prevention*
      The charge will be to gather background information and evidence that can be used by the full Advisory Group to effectively describe a continuum of services that includes clinical, community, and integrative approaches to prevention.
- Dr. Levi will rework the charge of the working group on Engagement to reflect that the National Prevention Strategy includes businesses and communities along with federal agencies.
- Defining the charges so that the Prevention Council can act on the Advisory Group's advice and recommendations if they so choose.
- Provide feedback on external experts and external advisors that the Advisory Group might contact for participation in the working groups.
- Determine how best to publicly express support for the broad concepts of the National Prevention Strategy.

Next Steps for the Prevention Council and Staff

- The Prevention Council is nearing completion of the National Prevention Strategy.
- The annual report is due on or before July 1, 2011.
- The Prevention Council is working to reach a consensus definition of complementary medicine to include in the National Prevention Strategy, and will consider content from the Advisory Group and National Institutes of Health (NIH).

- Consider ways to highlight the issue of early childhood when the National Prevention Strategy is represented in summary form.

I. WELCOME 12:00 P.M. - 12:25 P.M.

Dr. Jeffrey Levi, chair of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (the Advisory Group) welcomed participants to the second meeting of the Advisory Group. He explained that the National Prevention, Health Promotion, and Public Health Council (the Prevention Council) is mandated by the Affordable Care Act (ACA) to produce the National Prevention Strategy (the Strategy). At its first meeting in mid-April the Advisory Group had a robust discussion and provided the Prevention Council staff with significant input on the draft framework of the Strategy.

Dr. Levi said the purpose of this day's discussion would be to hear an update on the status of the Strategy, including what changes may have been made to it; provide some additional input; and begin to think about next steps. He noted that the Strategy will only be of value if it is implemented. Therefore, a large portion of the meeting would be devoted to discussion of how the Advisory Group can contribute to implementation of both the Strategy and the basic principles of ACA. Dr. Levi thanked the public for joining, and explained that questions submitted online during the meeting would be noted in the official public record.

Dr. Levi introduced Dr. Corinne Graffunder, Acting Designated Federal Officer (DFO) for the Advisory Group and Director of National Prevention and Health Promotion Strategy at the Centers for Disease Control and Prevention (CDC). Dr. Graffunder took roll call for the official record. Dr. Levi then introduced Vice Admiral Regina Benjamin, Surgeon General of the U.S. Public Health Service and chair of the Prevention Council. Dr. Benjamin welcomed participants to the meeting, and then welcomed the two newly appointed members of the Advisory Group.

- Dr. Judith Palfrey, professor of Pediatrics at Harvard and Director of the Center of Global Pediatrics at Boston Children's Hospital. Dr. Palfrey is also the immediate past president of American Academy of Pediatrics (AAP). Dr. Palfrey expressed her gratitude for being included in the Advisory Group and said that prevention is central to the nation's health, especially for children.

- Dr. Richard Binder is Medical Director at McKesson U.S. Oncology, and a professor at both Virginia Commonwealth University and Georgetown School of Medicine. Dr. Binder expressed his hope that the Strategy will help make a major impact on the future of healthcare delivery.

Dr. Benjamin provided an update on the activities of the Prevention Council. She noted that the Prevention Council is nearing completion of the Strategy. Shortly after the April Advisory Group meeting, the Prevention Council met to review and approve revisions to the Strategy based on the Advisory Group's input. Dr. Benjamin explained that, in addition to being required to submit the Strategy, the Prevention Council is required to submit an annual report to the President and Congress on prevention, health promotion, and public health activities. The annual report, due on or before July 1, will cover the meetings that have been held to go over the Strategy, including those of the Advisory

Group**.** The Prevention Council is currently drafting that report. Dr. Benjamin expressed her gratitude for the Advisory Group's work and stated that she looks forward to continuing to work with the Advisory Group.

Dr. Levi thanked Dr. Benjamin and acknowledged that several dozen representatives and other interested parties from the 17 agencies comprising the Prevention Council were in attendance. He reminded the Advisory Group members that this activity is meant to be government-wide; he asked them to think across agencies as they make recommendations for implementation of the Strategy.

II. UPDATE ON DEVELOPMENT/FRAMEWORK OF NATIONAL PREVENTION STRATEGY, 12:25 P.M.-1:00 P.M.

Dr. Levi then turned the meeting over to Dr. Corinne Graffunder for updates on the Prevention Council's development of the Strategy.

Dr. Graffunder reminded members that the previous iteration of the Strategy included a framework composed of 4 pillars (Healthy Communities, Preventive Clinical and Community Efforts, Empowered Individuals, and Elimination of Health Disparities); three cross cutting priority areas; and seven strategic directions. During the first meeting, the Advisory Group had expressed concern about overlapping priority areas and pillars. They had also emphasized that, while the priorities had recommendations and actions associated with them; the pillars were overarching and lacked content. The Prevention Council addressed these concerns.

Dr. Graffunder then presented the revisions to the framework of the Strategy that had been approved by the Prevention Council during their last meeting. She further explained that the current iteration of the Strategy remains a work in progress. Major revisions to the framework of the Strategy include:

- The goal statement has been revised; the new phrasing is: **"increase the number of Americans who are healthy at every stage of life."** The previous goal statement was very specific to increasing healthy life to the age of 85; however, the Advisory Group encouraged the Council to think about a more aspirational statement, which would encompass longevity, quality of life, and life stages. The Prevention Council is currently working with the National Center for Health Statistics to incorporate metrics to track and monitor progress over time in achieving this goal statement.

- **The Strategy now comprises one goal, four strategic directions, and seven priority areas.** The new strategic directions were created by building out the content using concepts in the four pillars and priority areas of earlier versions of the Strategy. Dr. Graffunder demonstrated that no content was lost in creating the new framework by using the example of the old priority area "Prevention and Public Health Capacity". In the new framework, most of the content from this area went into the strategic directions of "Healthy and Safe Community Environments" or "Clinical and Community Preventative Services." The new Framework includes concrete, evidence-based recommendations for each area. In addition, specific action items were included that align with the four strategic directions and seven priority areas.

- Dr. Graffunder presented the new recommendations for the framework that were approved by the Prevention Council. She noted that the other recommendations were maintained; but some were edited or slightly changed. Each recommendation has been crafted to be at a "high-level," so that each of the partners can identify how they can help to achieve the recommendation, or select the recommendations that most closely align to their own work. The new recommendations include:

    - To the Clinical and Community Preventive Services strategic direction, **"Enhance coordination and integration of clinical, behavioral, and complementary health strategies"** was added. The Prevention Council will include evidence-based approaches that support this recommendation.

    - To the Empowered People strategic direction, **"Improve income, education, and employment opportunities," and "provide individuals with tools and information needed to make healthy choices"** were added. Dr. Graffunder explained that this recommendation incorporates the Advisory Group's input on the importance of social determinants of health from the first meeting.

- Three new recommendations were added under the Elimination of Health Disparities strategic direction. They are: "**increase the capacity of the prevention workforce to identify and address disparities**"; "**reduce disparities in access to quality of care**"; and "**support research to identify effective strategies to eliminate health disparities**".

Dr. Levi opened the floor for questions and/or comments. He reminded the Advisory Group that the Strategy is now undergoing final review. The Advisory Group's questions and comments included:

- Dr. Sharon Van Horn commented that the new framework is more representative of the Strategy's mission, and the graphic is excellent.

- Dr. Vivek Murthy agreed that the graphic is much improved. He asked Dr. Graffunder how the word "complementary" will be defined in the Clinical and Community Preventive Services strategic direction. Dr. Graffunder said the Prevention Council is working to define it; they will consider materials provided by the Advisory Group and work done by the NIH to reach a consensus definition for inclusion in the document.

- Dr. Palfrey approved of the new graphic, and of the prominent representation of individuals with disabilities in the Strategy. She expressed concern that even though the Strategy does include language about reproductive and sexual health, children and families are not sufficiently incorporated in the "Empowering People" strategic direction. She urged the Prevention Council to include early childhood and "healthy beginnings" more prominently in the Strategy. Dr. Graffunder assured Dr. Palfrey that the nature of the content that she was referring to is included in the Strategy in multiple places. Dr. Graffunder noted that the Prevention Council could consider ways to highlight the issue of early childhood when the Strategy is represented in summary form.

- Dr. Susan Swider also applauded the graphic. She suggested adding "population" to the recommendation under the strategic direction of Clinical and Community Preventive Services, so the revised language would say "enhance coordination and integration of clinical, behavioral, population and complementary health strategies". This would address the merger of clinical prevention in the individual provider visit, for example, with work that can be done in a local park district around safety issues. Dr. Graffunder assured Dr. Swider that there is text in that chapter that more effectively represents the different populations than does the graphic.

  Dr. Graffunder noted that she was not sure the Prevention Council could revisit the recommendations while the Strategy is undergoing review, but there may still be opportunities for revisions at a later point. Dr. Levi concluded the question and answer period and stated that the Advisory Group is eager for the final Strategy.

III. ADVISORY GROUP'S ROLE IN IMPLEMENTATION 1:00 P.M. - 1:35 P.M.

A. Implementation of the National Prevention Strategy

Dr. Graffunder reviewed section 4001 of the ACA to provide background on the statutory role for the Prevention Council:

1) Provide coordination and ongoing leadership at the federal level among all departments.

2) Put into place processes for continual public input.

3) Establish agency-specific actions to address the recommendations.

4) Monitor and track federal actions.

5) Produce an annual status report.

Dr. Graffunder said partners will play an important role in making this the Strategy a national one. She then talked about other components for a more optimal implementation including networking and communication across multiple sectors with multiple partners and alignment with evidence-based strategies and what is already being done. The Prevention Council has started discussions on how this can advance capacity building and network development, partner engagement, and analysis and research. Dr. Graffunder commented that the Prevention Council has also started discussions on a process for evaluation and accountability through implementation planning. The members will specify what activities each department will be conducting and how these actions will be tracked and monitored.

The Prevention Council has also discussed the role and opportunities for other organizations and partners to help advance the Strategy. In particular, significant support from the Advisory Group and their constituencies, and federal departments' will be needed for long term commitment to ensure successful implementation of the Strategy. Dr. Levi noted five ways in which the Advisory Group can assist in implementation of the Strategy:

1) Provide guidance around implementation. The Advisory Group can express their view and recommendations about implementation of the Strategy.

2) Help identify areas where more research is needed to build the evidence base. Many of the Advisory Group members have that type of expertise and experience to contribute to the Strategy.

3) Serve as a catalyst, rather than just provide guidance, to advance specific elements of the Strategy. Although the Advisory Group does not have any formal authority, they can use their platform to be a catalyst for specific elements of the strategy. The Strategy will have many recommendations, and the Advisory group can determine a way to focus their efforts.

4) Play an oversight or watchdog role and use the Strategy's metrics to monitor progress.

5) Help with engagement, which was discussed at the last meeting in the context of the working groups. The Advisory Group is representative of a diverse group of constituencies, coming together to form a constituency around prevention. The Advisory Group needs to ensure that the philosophy of the broad government-wide approach to prevention is embraced by all of the constituencies.

Dr. Levi said that the formal work of the Advisory Group must be done with federal officials present. The creation of working groups will allow the Advisory Group to bring in other people with relevant expertise. The working groups cannot make recommendations, but they can gather information and bring ideas to the full Advisory Group, where they can be considered. Due to limited funding and resources, and that the Advisory Group will likely only meet in-person twice a year, working groups are an excellent option to extend the Advisory Group's work. With that, Dr. Levi opened the discussion to questions.

Ms. Barbara Otto asked Dr. Levi if he envisioned hearing from those at the state and local levels about capacity needs and their thoughts on implementing the Strategy. Dr. Levi agreed it would be important to empower communities; he mentioned that the public health system is heavily dependent on the state and local levels, and said it would be critical to obtain state and local level buy in to the Strategy.

Dr. Graffunder noted that it would be a useful for the Advisory Group to gather feedback from the communities they represent. If state and local partners feel the Strategy is being imposed upon them rather than part of the process, it will be harder for them to share the vision of implementation. Dr. Benjamin commented that the Strategy is not just about federal, state, and local governments; it also includes communities, individuals, partners, and businesses.

Dr. Patrik Johansson asked Dr. Graffunder to elaborate on evaluation and accountability across the 17 different federal departments. Dr. Graffunder said the Prevention Council is hoping to more fully understand and develop evaluation and accountability components as it continues implementation planning. The current draft Strategy has a number of metrics related to each priority areas, but no individual department or sector would be responsible for a particular metric. The hope is that the work of the Strategy will help to improve outcomes in those areas. The current draft Strategy includes statements about what the federal government will do in each of the priority areas. Those statements are currently broad because the Prevention Council did not have time to solidify department-specific commitments. In moving forward with implementation, the Prevention Council has discussed not only defining department-specific actions but also trying to identify collective actions that could be coordinated.

Dr. Graffunder mentioned that as the recommendations are refined, the Prevention Council can include process-oriented measures in its annual reports to determine whether the departments are doing what they said they would; whether they are involved in implementation; and using the metrics to see if we are making a difference in health status for some of the indicators.

Ms. Semonoff later asked for clarification of whether each department would be assigned, or be asked to choose, specific strategies once the implementation begins. Dr. Graffunder said the Prevention Council has discussed explicitly defining actions that the each department could commit to that would align to some number of the recommendations. Not every department would commit to every recommendation, but every department would have the opportunity to identify how it can contribute to advance the recommendations.

The Prevention Council will also be looking at standard data sources for the overarching metrics; however there is a strong sentiment against developing new data collection efforts or systems. The Prevention Council is encouraging use of existing resources and infrastructure. The departments have expressed an interest in looking into their own sectors for how they can monitor progress over time.

Dr. Palfrey asked if the Advisory Group is planning to have a working group that would focus on those areas where the nation progress is moving "backwards." She provided two examples of areas where the nation is currently becoming less effective in implementing. One example is childhood immunizations, which are the most effective preventive strategy known; however, because people are not seeing the illnesses that vaccines protect against, many do not understand the immense value of immunizations and the rates are decreasing. The second example is around injuries, and seeing questions in terms of firearm discussions in the doctor's office. Dr. Levi asked Dr. Palfrey to wait until after the two proposed workgroup's charges had been described to see if there was need to address this issue separately. He also expressed the view that it is important that the Advisory Group frames issues in ways that are as affirmative as possible. Dr. Palfrey noted that she agreed with this concept in general, but did urge the Advisory Group to think about the importance of those preventive strategies that have been proven effective.

Given the Advisory Group's role as being catalysts for moving parts of the strategy forward, Dr. Murthy questioned whether there would be local variation in the types of implementation efforts, and whether it would be better to focus on certain parts of the Strategy in certain areas of the country.. He also asked about opportunities within the Advisory Group to brainstorm about local implementation. Dr. Levi expressed that he is open to ideas but was unsure whether the working groups are structured to accommodate that work. He mentioned the possibility of finding an appropriate

way within the FACA rules that the Advisory Group can communicate informally about local implementation ideas and have face-to-face meetings about those issues.

Building on Dr. Murthy's comment, Mr. Ned Helms mentioned that many of the 17 federal agencies have regional offices that could work with communities throughout the nation to develop effective implementation strategies.

Dr. Richard Binder asked if there was a role for the Advisory Group in communicating with the general public and health care providers about the importance of prevention. Dr. Levi said that would be a large role to take on; the more likely role for the Advisory Group would be to ensure that communication is undertaken by the government, as there are some Prevention and Public Health Funds for those kinds of education activities.

B. Creation of Working Groups

Dr. Levi explained the role of a working group. Working groups would gather information, synthesize that information, and present their findings to the full Advisory Group. The Advisory Group would then make recommendations based on that information. Dr. Levi later explained that he had spoken with the Robert Wood Johnson Foundation, and they are willing to provide some research support for the two proposed working groups. This will enable some staff support.

1. Working Group on Engagement

Dr. Levi proposed a name change for the first working group from the "Working Group on Co-Benefits "to the "Working Group on Engagement" to create a broader constituency for embracing a culture of wellness and prevention throughout the federal government. This working group can also be defined in terms of reaching out to local and state communities and engaging them in similar ways; and focusing on federal agencies, but thinking about regional approaches.

The charge of this working group will be to provide background information to the full Advisory Group to assist in identifying implementation steps associated with the Strategy so as to assure a culture of wellness and prevention throughout the federal government. The working group will do this by defining the co-benefits of embracing a prevention and wellness perspective for federal agencies represented on the Prevention Council; showing how all agencies can contribute to health; and identifying how a focus on health and wellness can result in non-health agencies more effectively achieving their mission. Practically this could be done by identifying opportunities for the Advisory Group to create relationships with similar FACA committees in the 17 agencies, to facilitate coordination and alignment, as well as the regional approach. California has done a lot of this work through their Health in All Policies Task Force and could be a toolkit for the Advisory Group and Prevention Council.

Dr. Swider agreed with the new name of the working group and confirmed that the proposed activities seem realistic. Dr. Murthy asked about the timeframe for the working groups' efforts. Dr. Levi envisioned the work groups meeting once or twice between this meeting and the next full Advisory Group meeting, and then reporting back to the Advisory Group. The Advisory Group could then refine the charge of each working group. Dr. Levi envisioned, as a process, each working group could meet, use resources available to gather information, present the information at a public meeting of the Advisory Group, get feedback from the Advisory Group, and then continue its work. Ms. Otto echoed the excitement about the working group and mentioned that there is a lot of activity happening in Chicago that can build momentum. Sister Charlotte Kerr said the Strategy targets individuals, communities, and businesses, and they should be included in discussions of the charge of this workgroup. She said it appears the working group only focuses on how to affect federal agencies and reiterated the importance of businesses. Dr. Levi assured Sister Kerr that the language of the working group's charge would be reworked to reflect that the Strategy includes businesses and communities along with federal agencies.

2. Working Group on Prevention and Integrative Health in the Affordable Care Act.

Dr. Levi then introduced the second Working Group on Prevention (Clinical and Non-Clinical) and Integrative Health in the Affordable Care Act. **This group will be charged with gathering background information and evidence that can be used to effectively describe a continuum of services that includes clinical, community, and integrative approaches to prevention.** This working group will not be limited to implementation of the Strategy but will address the general implementation of the Affordable Care Act. Dr. Levi noted the importance of making sure that prevention and an integrative approach to health promotion are always top priorities in the redesign the health care system as part of ACA. The first stage in that process is to systematically gather the information necessary to identify opportunities where discussions are being made that can make a difference. The working group will have to prioritize where to focus, such as the essential benefits and who is delivering them; making sure that preventive services remain a priority; focusing on an integrative approach to provider networks; and identifying the services available. Some decisions will be made at the federal level, while others will be done at the state level. There is a broad range of issues that decision makers at the federal, state, and local levels could be educated on. The Advisory Group can use its oversight function to ensure that decision-makers are moving forward on these issues.

Additionally, Dr. Levi commented that research may fall in this work group to some degree because we don't necessarily have proven models for providers to take a truly integrated approach to healthcare. This may be an opportunity for working with the Center for Medicare and Medicaid Innovation.

Dr. Palfrey said this working group is important because the general public probably believes that it is easy to provide preventive services, when in fact it is very difficult. One of the problems surrounding prevention is the scoring of preventive services. Many of the services that would bend the cost curve, including much of the obesity work, were not allowed to be scored because these preventive activities are too long-term and the benefits would not be seen for some time. Dr. Palfrey also mentioned that, although the public may think they exist, immunization registries at the state level don't exist. She provided the example that Bright Futures, prevention services recommended through the Maternal and Child Health Bureau of the Health Resources and Services Administration, has been facing several implementation issues as part of ACA that the general public probably does not know about.

Dr. Levi suggested deferring the preventive services scoring issue to the Institute of Medicine, as they are creating a committee on valuing prevention. Dr. Levi agreed that the other issues raised are important implementation issues that are generally assumed to be covered under the ACA.

Dr. Van Horn questioned the definition of integrative approaches to prevention and was concerned that it does not include complementary medicine. She expressed concern that the language focuses on integrating existing services, whereas integrative health care is about the integration of western medicine with complementary forms of medicine. Dr. Levi assured Dr. Van Horn that the charge is meant to include complementary forms of medicine. He mentioned that there are complementary therapies that are treatment-focused and there are complementary approaches that are a form of prevention. The Advisory Group's mission is to stay focused on prevention.

Mr. Helms mentioned that recently released Accountable Care Organization (ACO) regulations do not include community health centers, which are probably among the most important vehicles for delivering preventive health services to vulnerable populations. He emphasized the importance of including community health centers in implementation efforts. He also believes it is important for that that type of exclusion to get pointed out early on in the implementation process. Dr. Levi responded that it becomes a challenge for the Advisory Group to respond to some of these specific events and that it would be difficult for the Advisory Group to comment on ACO regulations, which have already been released. He proposed instead for the Advisory Group to identify milestones where decisions need to be made as timelines are identified and where the Advisory Group may be able to influence some of those decisions moving forward.

Ms. Semonoff questioned the charge of the working groups and about exerting the Advisory Group's influence as widely as possible, namely through the Prevention Council. She proposed defining the charge in a way that the Prevention Council can act on the Advisory Group's voice, research, advice and recommendations if they chose to do so. Dr. Levi agreed and thought Ms. Semonoff's comments nicely illustrated the boundaries of the Advisory Group's responsibilities.

Dr. Bigby raised two issues. First, the ACO regulations are in reference to Medicare and reforming the delivery system and payment model related to shared savings, so it is much narrower in scope than people understand it to be. The exclusion of community health centers reflects the relative lack of understanding about the role that community health plays across populations. Second, it is important to talk about how medical and clinical delivery systems, even when integrated, need to have some sort of intersection and relationship to community health or public health activities that are related to prevention strategies so that people do not lose the understanding that clinical care is not the only system that can integrate these functions. She said there is an opportunity to think about how it is possible to

better use public health dollars through the intersection of clinical care and public health to ensure that these types of health goals are achieved. Dr. Levi agreed this would be a practical way to ensure that this new delivery systems take on the prevention responsibilities that it should, and thereby freeing public health resources so that it does not have to spend its resources replacing what the health delivery care system ought to be doing in the first place. **Dr. Levi will work on revising the charges to reflect the discussion and will circulate the revisions.**

Ms. Kerr expressed concern that the second working group does not speak to the role she though it was supposed to play. She wanted to be sure that the discussion of integrative approaches was working out of a conceptual framework that the individual, the community, and the environment are one and they interact with each other. Some of the expressions of this understanding are that health care is primary care and that there are many things that can affect the idea of America being healthy at every stage of life. She believes that the second working group's charge is more expanded than what had been proposed. **Dr. Levi said that he would revise the language in the charge to be more reflective of her comments, although he felt that much of what she said is implicit in the charge**. Dr. Levi recognized that there may be some opportunities to introduce the notion of community into the healthcare context, such as in the Center for Medicare and Medicaid Innovation, which has community interventions as one of its priorities**.**

Dr. Levi asked two things of the Advisory Group members:

1) Volunteer to serve on one or both of the working groups with the understanding that this may take some time and;

2) Provide feedback on who else the Advisory Group might reach out to serve as external experts and external advisors.

IV. UPDATE ON THE PLANS FOR RELEASE OF THE NATIONAL PREVENTION STRATEGY 1:35 P.M. - 1:50 P.M.

Ann Widger, Deputy Director, HHS Office of External Affairs, provided an update on plans for releasing the Strategy. The Office of External Affairs is eager to engage with the sixteen federal departments across the Administration for the rollout, and wants to ensure this is an opportunity to inspire the country to lead more prevention focused lives and draw attention to how the Affordable Care Act contributes to these efforts. She expressed hope that the Strategy would be released in mid-June. Ms. Widger mentioned that federal partners, as well as other public sector and private sector partners (e.g., schools, businesses, non-profits), will be involved in the roll out of the Strategy to ensure that its implementation is a national effort. Ms. Widger welcomed the Advisory Group's participation and input as the details for the roll-out emerge. HHS will highlight prevention throughout the month of June, and the release of the Strategy will be one of the anchor events.

Ms. Widger noted that HHS has been working with ten HHS regional offices during development of the Strategy and is looking forward to continuing to collaborate with them for roll out and implementation of the Strategy. She added that the Office of External Affairs will reach out to the Advisory Group members with a complete and formal roll out plan, in the meantime she invited members to submit ideas and input for the rollout directly to the Office of External Affairs at externalaffairs@hhs.gov. She added that the Strategy is a national effort, not just a report by the government, and it will require involvement by all corners of the country, not just those in Washington, D.C. She thanked the Advisory Group members for their leadership and partnership to date.

Dr. Levi said he will be advocating for maximal Advisory Group involvement in the roll out. That is one of the easiest ways for the Administration to show that the Strategy is not just an internal document, and that it reflects the

importance of prevention within ACA. He added that the Strategy is one of the early deliverables of ACA and that prevention is important to the public.

Dr. Levi reminded Advisory Group members that they had received a draft resolution from fellow member Valerie Brown, who was not present on the call that day. The document is based on much of the language from the earlier version of the Strategy. He suggested that Advisory Group members review it and send comments directly to Ms. Brown. The Advisory Group could then formally decide how to publicly express support for the broad concepts of the Strategy—perhaps through a revised version of this resolution or other means.

Ellen Semonoff later mentioned that Ms. Brown's draft resolution is based on the earlier version of the draft framework and therefore not quite in tune with where the Advisory Group is with the current framework. **Dr. Levi said he would talk with Ms. Brown to request that she update the draft; the draft could then be re-circulated to the members for comment**

Dr. Levi reminded the Advisory Group members that at the last meeting there was talk of creating a sign-on statement that would enable non-governmental organizations and community groups to endorse the general principles of the Strategy. Ms. Widger noted that a sign-on support letter would be helpful in the roll out efforts. Dr. John Seffrin noted that those on the Advisory Group who represent large organizations with communication capacity can work with their organizations to create supportive statements and efforts. They can highlight the ways in which the roll-out and implementation of the nation's first ever prevention plan will assist in helping achieve their organizations' missions. Dr. Murthy asked Dr. Levi what kinds of benchmarks the sign-on letter should reach in terms of regional representation, and number of groups on board. Dr. Levi responded that the issue could be further explored off-line**.**

V. DISCUSSION OF POTENTIAL AGENDA FOR NEXT FACE-TO-FACE MEETING 1:50PM - 2:00PM

Dr. Levi stressed, though currently vague, that the agenda is designed allow for as robust and substantive a meeting as possible. He also mentioned that the working groups will have a significant amount of leg work to generate discussion. Dr. Levi hopes to report on the progress of the working groups, including their potential recommendations. Also included in the next agenda will be a report on the release of the Strategy and hearing from the Prevention Council about what has been done on implementation since the release. Dr. Levi would like to spend the bulk of the time discussing issues surrounding engagement and implementation of the ACA from the working groups.

Ms. Kerr mentioned that the Advisory Group still has 8 or 10 people remaining to be appointed, especially in the area of integrative health, which is mandated language and so as of right now, this group is incomplete. Dr. Levi and Dr. Benjamin both echoed their desire to have a complete Advisory Group.

Appendix: Public Comments

Public Participate	Comment	Time
Scout Network for LGBT Health Equity	First, thank you for including more disparity pops in the newest version, (esp gender identity). But... the recently released CDC $100M CTG call for proposals does not prioritize these same disparity pops, when will the major funding moves be harmonized?	12:30pm
Bruce Blehart American Academy of Sleep Medicine	From the initial meeting to today, we have questioned how the framework addresses incorporating effective sleep.	12:30pm
Venus Gines DIA DE LA MUJER LATINA, INC	In your recommendations to Eliminate Health Disparities, are you including Increasing Community Engagement via Community Health Workers and Promotores?	12:30pm
Melissa Thompson Mercer University, School of Medicine	Regarding Health Disparities, would it not be very important to include an item recognizing the need for research that effectively identifies the factors which contribute to health disparities? It appears to be a major omission from the recommendations.	12:31pm
Eli Briggs NACCHO	I would like to see more specifics about how public health and prevention capacity will be reflected in the strategy since it is no longer a strategic direction. It is essential to meeting the overall goal through strategic directions.	12:33pm
Martina Taylor NIH	Regarding early-life exposures/experiences, I think a life-stages approach within all 7 priority areas will get to that concern, as well as other health issues that are specific for particular life stages.	12:34pm
Jon Rudin San Diego Healthcare Compliance	Are you familiar with ACE study by Dr's. Felitti and Anda. Their chapter in book,The Hidden Epidemic: Impact of Early Life Trauma on Health and Disease, is profound. Recommendation for intervention with greatest impact on health? A: parenting classes!	12:35pm
Brennan Rhodes CCCEH	Will the strategic direction "Healthy & safe community environments" incorporate increase awareness and research support for environmental health exposures that can impact health outcomes during pregnancy and early child	12:40pm

	development?	
Marco Meneses FL Broward County Health Department	I would love to be an active participant of this Advisoty Group. Thanks	12:48pm
Josephine Fowler JPS Health Network	I would also like to be an active participant. Thanks	12:51pm
Jane Malone National Center for Healthy Housing	What's the Advisory Group's role in ensuring articulation between the Strategy and investments under the Prevention and Public Health Fund?	12:54pm
Marco Meneses FL Broward County Health Department	I work with the Broward County Health Department, as Coordinator for Chronic Disease Prevention and PREVENTION is my full time job.	12:54pm
Donald Ohiowele MAPAC	what is required of a private individual as far as implementation of preventive strategies for the committee at federal level. Are there online submissions of new strategies? would private individuals with such strategies get support?	12:56pm
Jeanne Alongi NACDD	Thank you for the opportunity to listen to the meeting today. I appreciate the thoughtful participation of the Advisory Group members on behalf of all Americans. I look forward to the evolution of this framework and its application to the work of state and local health departments. What is the role of public health practitioners in these settings in the implementation of this framework?	1:01pm
John Hill National Alliance for Medicaid in Education	Very glad to hear the recognition of healthy programs in schools and how schools today not only play a valuable role in prevention, but also in monitoring and treatment of health related issues.	1:09pm
David Felton American College of Prosthodontists	It appears that the panel has done an outstanding job with this issue. However, I note that there does not appear to be any representation on the panel from dentistry. Oral health is directly related to general systemic health, and should be represented.	1:12pm
John Hill National Alliance for Medicaid in	Strongly concur about Dental.	1:19pm

Education		
Melissa Thompson Mercer University, School of Medicine	Would a socioecological model provide a clearer framework here? It seems that would more effectively frame the scope and novelty of what the work group appears to be addressing.	1:36pm
Helen Luryi National Partnership for Women and Families	Whom is invited to volunteer for the Working Groups? Is it limited to Advisory Group members only? Thank you.	1:38pm
Elizabeth Royal SEIU	Can non-panelists service on the subcommittees?	1:40pm
Linda May Kansas City University of Medicine and Biosciences	I am not sure what type of experience the Advisory Group is looking for in the subcommittee and group membership, but I am open to helping this effort in any way that I can.	1:47pm
Suzy Harrington NCQA	socio-ecologic model is a great idea	1:49pm