Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
October 3, 2011 – October 4, 2011
GSA Auditorium
1800 F Street, NW
Washington, D.C.

ATTENDEES

Advisory Group Members

Jeffrey Levi (Chair), JudyAnn Bigby, Valerie Brown, Jonathan Fielding (participated in Day 2), Patrik Johansson, Charlotte Kerr, Elizabeth Mayer-Davis, Vivek Murthy, Barbara Otto, Linda Rosenstock, John Seffrin, Susan Swider, Sharon Van Horn, Richard Binder

Designees of the National Prevention, Health Promotion, and Public Health Council

Jack Stein (Office of National Drug Control Policy), Dotti Miller (Environmental Protection Agency), Linda Cook (Corporation for National and Community Service), Elena Lynett (Department of Labor), Andrew Rein (Department of Health and Human Services)

HHS Staff	Panelists
Regina Benjamin, Corinne Graffunder	Ursula Bauer, William Novelli, Wayne Jonas, Colonel Christian Macedonia, Terri Tanielian, Clement Bezold, Lesley Russell, Aaron Wernham, Lee Wilson, Amy Nevel, James Hester, Anand Parekh

ACTION ITEMS AND NEXT STEPS

CDC/OSG:

- The Office of the Surgeon General will develop a toolkit that includes resources to organize regional meetings in support of the National Prevention Strategy.
- Dr. Graffunder will share approved PowerPoint slides on the National Prevention Strategy with Advisory Group members so that they can present this content to their individual networks.

Advisory Group

- Discuss strategies for obtaining external input, and find ways to incorporate it.
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- Develop short-, medium- and long-term objectives.
- Send community success stories to Dr. Graffunder, to be shared with Office of the Surgeon General.
- Form a working group to synthesize the recommendations that emerge from this meeting
- Form an engagement/communications working group
- Suspend activity of Prevention and Affordable Care Act (ACA) working group
- As follow up, Advisory Group members should receive:
    - A brief outline of the rollout activities planned for the next nine months
    - An overview of the purpose and goals of the regional meetings
    - A summary of individual Advisory Group members accomplishments to-date (This information could be compiled for PowerPoint slides and talking points)
    - A list of identified champions who should be contacted by the Advisory Group

Monday, October 3rd

I. WELCOME BY CHAIRPERSON AND DR. BENJAMIN 9:00 A.M. – 9:20 A.M.

Dr. Jeffrey Levi, chair of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (hereinafter called the Advisory Group), welcomed participants to the second in-person meeting of the Advisory Group. Dr. Levi stated that the National Prevention Strategy (NPS) has recently been released; the NPS has represented "a major step in redefining what health means in the U.S

Dr. Levi thanked the working group participants and outside experts for attending and reviewed the meeting agenda:

Day 1: Prevention and Integrative Health Working Group, looking at prevention within the context of implementation of the Affordable Care Act (ACA). Three topics were addressed: 1) improving the understanding and uptake of preventive services; 2) prevention opportunities in HHS' implementation of the essential benefits package and the Center for Medicare and Medicaid Innovation; and 3) how prevention and health is framed in the context of health reform and how the concept of resiliency is related.

Day 2: Engagement Working Group, looking at how implementation of the NPS can assure a culture of health and wellness throughout the federal government.

Noting that it may be difficult to draft recommendations by the end of this meeting, Dr. Levi suggested the creation of a writing working group to quickly develop recommendations for the full Advisory Group to consider at the next public meeting by teleconference. All AG members agreed.

Admiral Regina Benjamin, U.S. Surgeon General and chair of the National Prevention, Health Promotion, and Public Health Council (hereinafter called the National Prevention Council), stated that the NPS was launched on June 16th, 2011. It received significant press attention and a great deal of organizational support. The NPS embraces many topics that are of vital importance, and it is imperative that the National Prevention Council's work be synchronized with that of the Advisory Group.

II. NATIONAL PREVENTION COUNCIL: NPS IMPLEMENTATION PANEL 9:20 A.M. – 10:00 A.M.

Dr. Corinne Graffunder, the Acting Designated Federal Officer (DFO) for the Advisory Group, introduced four of the National Prevention Council designees who had been invited to present an update on their progress to the Advisory Group. The National Prevention Council organized four working groups around each of the four strategic directions of the NPS. A co-lead of each working group was present to talk about the beginning stages of their work. These individuals were:

- Dotti Miller, Office of Research and Development, Environmental Protection Agency (EPA)
- Jack Stein, Office of Demand Reduction, Office of National Drug Control Policy (ONDCP)
- Linda Cook, Office of AmeriCorps State and National, Corporation for National and Community Service (CNCS)
- Elena Lynett, Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration (EBSA), Department of Labor (DOL)

Dr. Dotti Miller, co-lead for the Healthy and Safe Community Environments Working Group, explained that the National Prevention Council working groups are in the early stages of their work, but they felt it was

important to meet with the Advisory Group. The Healthy and Safe Community Environments Working Group is co-led by EPA and HHS. Dr. Miller noted that as the Advisory Group will be looking at the opportunity for health impact assessments later at this meeting, the National Prevention Council has received background on health impact assessments and is considering how they could be integrated into federal departments and federal plans moving forward.

Dr. Jack Stein is co-leading the Community and Clinical Preventive Services working group. Dr. Stein is co-leading this working group with the Department of Veterans' Affairs and anticipates it will focus on infrastructure development. One relatively definable example of issues that his working group is addressing is incorporating screening and brief interventions (e.g., substance abuse screening and intervention) into all types of clinical settings. In his working group, Dr. Stein would like to focus on how to connect community- or population-based prevention services into existing infrastructures in the health care system, which he sees as more challenging.

Ms. Linda Cooke, co-lead for the Empowering People working group, said that her agency supports volunteerism and community service, including empowering people to take a more active role in their community, and that health is one of the pillars of their strategic plan. Ms. Cooke explained that her working group is still finalizing the selection of a co-lead and will update the Advisory Group once that information is available. The Empowering People working group will focus on prioritizing health and prevention not only for individuals but for communities.

Ms. Elena Lynett, co-lead for the Elimination of Health Disparities working group, explained that the DOL has focused on eliminating disparities and is interested in how to collaborate with the 16 other departments and agencies. The DOL has continually spent time thinking about the relationship between health and the viability of the current and future workforce. In addition, her department has focused on its ability to reach a large population because the DOL works on programs and policies that can impact the workplace. Her working group is in its beginning phases, and she is looking forward to working with the Advisory Group.

Advisory Group Discussion:

Advisory Group Member Valerie Brown praised the federal government's efforts to work together to support healthy communities. She noted the value of health impact assessments because they change the way individuals view land and water, and communities in general. She suggested that the National Prevention Council explore the possibility of using an alternate term for health impact assessment, as it brings to mind additional regulations and procedures. County governments do not want additional regulations and procedures, yet health impact assessments are important and therefore should be framed in a way that encourages its adoption.

Advisory Group member Dr. JudyAnn Bigby asked National Prevention Council representatives to describe the products being developed by each working groups. Dr. Miller responded that her working group is looking across the agencies, examining actions they are already taking, and identifying potential opportunities to synergize and move forward as a first step. Dr. Stein added that federal agencies have committed to implementing certain items in the NPS. Cross-cutting strategies are more challenging but exciting, and the working group can start thinking about the cross-cutting opportunities.

Advisory Group Member Dr. Vivek Murthy asked the National Prevention Council representatives how they are interfacing with community-based and advocacy organizations. Dr. Graffunder said that one of the

ongoing responsibilities of the National Prevention Council is ongoing public input and feedback; therefore, they will identify groups and individuals to interface with the National Prevention Council, such as in a panel similar to today.

Advisory Group Member Barbara Otto mentioned that the Advisory Group is interested in looking at whether the NPS will offer some sort of "crosswalk" to show areas of intersection among unlikely partners at the federal level. She was interested in a template for how the federal agencies are working together that might be adapted by those at the state and local levels. Ms. Otto noted that there are budget crises throughout the U.S. and encouraged the National Prevention Council to provide products to the local level for implementation.

Advisory Group Member Dr. Elizabeth Mayer-Davis asked about the composition of the working groups as she felt integration and communication across the 17 departments will make a big difference. Dr. Graffunder noted that every department is represented in at least one of the working groups, and that several departments are represented across all four working groups. Additionally every working group includes several representatives of the Department of Health and Human Services (HHS) serving as resource personnel and subject matter experts. Ms. Brown commended this cross-cutting work and said it should be held up as an example for local governments.

Dr. Johansson asked to what degree the health impact assessments were being discussed across the various working groups. Dr. Stein responded that there will be discussions and interaction between the four working groups about health impact assessments; he added his view that discussion across the working groups should be a foundational component of the National Prevention Council's efforts.

Dr. Levi said that the National Prevention Council and Advisory Group should aim for short-, medium-, and long-term victories. The National Prevention Council needs to be able to show meaningful changes in the short-term and help support a culture of collaboration among departments. Dr. Levi added that there needs to be a better way to integrate the Advisory Group and the National Prevention Council because the Advisory Group can provide critical external input and feedback since the Advisory Group is talking with folks on the ground.

III. REPORT FROM THE PREVENTION AND INTEGRATIVE HEALTH WORKING GROUP
PART 1: IMPROVING UPTAKE AND UNDERSTANDING OF PREVENTIVE SERVICES BENEFITS

10:15 A.M. – 11:15 A.M.

- JudyAnn Bigby, Secretary of Health and Human Services for the Commonwealth of Massachusetts
- Ursula Bauer, Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Department of Health and Human Services

Dr. Levi introduced the next topic, improving uptake and understanding of the preventive services benefits of the ACA. Noting the ACA offers a fairly comprehensive set of preventive services benefits with first dollar coverage (all services that have received an A or B rating from the U.S. Preventive Services Task Force.). Dr. Levi stressed the need to educate people about these benefits. The ACA created at least three opportunities to increase awareness and utilization: a public awareness campaign; the community transformation grants; and a new community health worker program (authorized but not yet funded).

Health reform and health insurance coverage in Massachusetts

Dr. Bigby highlighted:

Since the state's health reform efforts, 98 percent of Massachusetts residents are covered by health insurance, including 99.8 percent of children. In 2006, MA created outreach and enrollment grants administered through their Medicaid program. These supported educating and enrolling individuals in health insurance. These grantees reached about 23,000 individuals in 2006 and then 50,000 individuals per year thereafter.

The impact of this health insurance coverage and outreach is being tracked. The state identified priorities for prevention including tobacco cessation, flu vaccinations and cancer screenings. Smoking rates decreased, flu vaccination increased and colonoscopies increased in the first year of implementation. These results are significant as the Medicaid population smoking rate is almost double that of the general population in Massachusetts. As a result, 60,000 smokers used the new benefit and a state saw a decrease of 8 percent in the adult smoking prevalence. Additionally claims for heart attacks, chronic obstructive pulmonary disease, and complications relating to smoking during pregnancy all decreased in the first year, which has led to significant cost savings.

The percentage of low income women insured increased from 85 to 96 %. As a result of having regular health insurance, the adequacy of prenatal care has improved for the first time in a decade, especially among black and Hispanic women. Massachusetts and the city of Boston spent additional outreach dollars in areas where infant mortality rates are highest.

Finally, Dr. Bigby mentioned that payment reform is an ongoing activity in Massachusetts, as insurance payments can cover activities that were previously paid for with public health funds.

Advisory Group Member Dr. Linda Rosenstock asked about existing cost barriers in Massachusetts, such as deductibles and co-pays. Dr. Bigby indicated MA is tracking the impact of out-of-pocket costs for individuals and the impact on access. Co-pays and deductibles, particularly for the population under 500% of the FPL, make a difference and they report not getting care because of the cost. The benefits that employers are allowing are less and Dr. Bigby is concerned about a cost shifting. She also noted that while the ACA eliminates co-pays on preventive services many services, such as chronic disease management, still have out-of-pocket expenses.

Advisory Group Member Dr. Susan Swider asked if there are any particular methods that worked better for the outreach and enrollment grants. Dr. Bigby said each grantee is targeting different populations making it hard to identify a single method that is most effective. The diversity of the populations that each grantee is reaching has been one of the advantages of the grantees.

Community Transformation Grant program (CTG)

Dr. Bauer provided an overview of the Community Transformation Grants. Authorized under the ACA and funded through the Prevention and Public Health Fund, the purpose is to implement and evaluate evidence-based community prevention activities, address health disparities, and increase evidence-based practices in community prevention programming. These goals are aligned with the NPS priorities and strategic directions because they address tobacco use, physical activity, and other clinical services. CTGs aim to prevent primary and secondary conditions, and should lower cardiovascular disease rates and stroke rates.

CTGs emphasize reducing health disparities in specific population sub-groups. On September 28, 2011the CDC announced $103 million for 61 awardees, and the awarded grantees represent communities across the U.S.

CTG has two types of awards: implementation and capacity-building. Awardees are tribes, organizations, state-wide, territories, and other types of organizations. Thirty-five of the 61 funded grantees are receiving implementation awards with funding ranging from $500,000 to $10 million a year, depending on population size. The remaining twenty-six are capacity-building grantees with funding ranging from $147,000 to $500,000. Capacity-building grantees may be able to transition to become implementation grantees. .. There were many more quality applications than could be funded. . Implementation grantees must distribute half of their award (dollars) into their communities. Grantees must dedicate half their funds to key priority areas: tobacco, nutrition and physical activity, and clinical and other preventive services, particularly controlling high blood pressure and cholesterol. Some of the grantees are also pursuing other domains of health. All of the awardees will link clinical and community activities because they are mutually reinforcing activities.

The ACA requires that twenty percent of the Community Transformation Grant dollars be directed to rural and frontier areas. Thus, CDC is supporting national organizations to start capacity-building and implementation activities in smaller communities, rural and frontier communities. Dr. Levi asked Dr. Bauer what broad media outreach or public education is being contemplated by any of the grantees. Dr. Bauer indicated that the grantees are focused on traditional community outreach. They intend to identify high-need communities that do not have access or are not using the available services. Additionally the grantees are proposing activities to identify and engage allied health professionals, such as pharmacists, to ensure every person's interaction with the health care system can be to prevent and control chronic diseases. .Ms. Otto asked if the funding went to national organizations. Dr. Bauer responded that the American Lung Association, the National REACH Coalition, and the YMCA of USA are funded to make sub-grant among their networks, particularly in rural areas, to initiate activities similar to those of the implementation grantees. In addition, the American Public Health Association, the Asian Pacific Partners for Empowerment Advocacy and Leadership, the Community Anti-Drug Coalition, and the National Farm to School Network at Occidental College are funded to support particular aspects of community transformation grants and disseminate strategies through their network organizations. .

Dr. Mayer Davis asked if Dr. Bauer could describe the extent of which grantees may have collaborated with governmental agencies, either representing national or local efforts. Dr. Bauer responded that the grants required a multi-sectorial leadership team, and partnerships with different government and non-government entities. For example, bringing together urban and rural planning, housing, agriculture, and incorporated non-government organizations. All the grantees were successful in pulling together a multi-sectorial approach.

Dr. Murthy asked if there are mechanisms in place to share best practices and experiences. Dr. Bauer indicated that the CDC will ask "high performance" grantees to mentor other grantees. Additionally, the funded national organizations will disseminate best practices and lessons learned. Dr. Levi added that the Convergence Partnership, a public/private partnership, brings the CDC and public/private foundations together.

Sister Charlotte Kerr asked if any of the funded programs include teaching the community how to organize themselves in order to bring about changes within their culture. Dr. Bauer indicated there are not specific activities in the grant announcement for community mobilization. Ms. Brown noted it would be helpful to

know who the recipients are so the Advisory Group can nationalize this strategy, and know exactly what grants are being used for, and learn the expected outcomes. Dr. Bauer said the grantees are listed out on the CDC website with a brief summary of the key activities. She added that the ACA sets the outcomes. Most of the grantees requested more money than was available so CDC is renegotiating work plans, and once complete, that information will be on the website.

IV. REPORT FROM THE PREVENTION AND INTEGRATIVE HEALTH WORKING GROUP PART 2: IMPROVING UNDERSTANDING OF PREVENTIVE SERVICES BENEFITS THROUGH EDUCATION CAMPAIGNS 11:15 AM – 12:15 AM

- William Novelli, Distinguished Professor of Practice, McDonough School of Business, Georgetown University

Mr. Novelli indicated that he has worked on many campaigns promoting health promotion and chronic disease prevention. A 2010 review in Lancet stated that "mass media campaigns can produce positive changes or prevent negative changes in health-related behaviors in large populations. They can work through direct or indirect pathways." Novelli noted that media campaigns can disseminate well-defined behaviorally focused messages to large audiences at a low cost per head. However, some of these campaigns can backfire through not enough funding, a cluttered media environment, ineffective messages, or lack of audience resources.

Mr. Novelli noted that continuity and budgets matter. When connected to community activities, campaigns work best. Message sources are important as messages can be spread by physicians and other health professionals, celebrities, and people who represent a target audience. Multiple channels for the messages are necessary, including outreach through organizations, community channels such as schools, worksites, general media, and TV programs.

It is necessary to work on two levels. First, it is the environmental level. It is necessary to change the environment where people live. Second, it is important to change individual behaviors by coaching and other community activities to understand and change behavior. Research is critically important to successfully develop the concepts, messages, audiences, and message channels. Partnerships and alliances are important too. Leadership is key and the private sector as well as government and the non-profit sectors need to be involved.

Section 4004: Mr. Novelli recommended a strong practical plan which could be done in 90 days. The plan needs to be sequenced starting with what is currently available, should have multiple audiences, and be well-tested to make sure the messages are effective. The plan must not be politically motivated. It should focus on what works and include new sequences as more evidence on messages and benefits emerge.

Advisory Group Discussion.

Dr. Bigby asked Mr. Novelli to speak about making the public think of public health as a benefit to society. Mr. Novelli responded that it is not necessary to get the world to appreciate public health. He emphasized the need to focus on behavior change, risk factors and other areas where the public would benefit. Dr. Sharon Van Horn added that the term public health has a lot of baggage, and Mr. Novelli said that well-being is a good, testable term to use instead.

Ms. Brown asked how Mr. Novelli would utilize the different players, the different states and localities that have different strategies in place. Mr. Novelli advocates a sequenced program; as a program is implemented and we learn what works, the program can do more of those activities that work. Ms. Otto asked Mr. Novelli what he was proposing when he mentioned branding well-being in his strategic plan proposal. Mr. Novelli responded by saying that it might be possible to evolve into talking about branding well-being, but currently there is a lot of activity that cannot be placed under one umbrella and it is necessary to learn what works first.

Sister Kerr wanted to know how to teach people, through Mr. Novelli's suggested modalities, about their own behaviors and what they need to do on an individual basis to take care of themselves. Mr. Novelli responded by saying that it is necessary to work at an environmental and individual level. Media is good at environmental level change. When looking at an individual behavior change level, one is talking about teaching individual behaviors, coaching, and community level programs can target that. Additionally, social media is a new exciting area, and social media can reach certain segments of the population.

Dr. Murthy emphasized that the doctors he works with are supportive of the ACA and prevention. Yet, many do not feel they are being utilized in getting the message out about the prevention opportunities within the ACA. He asked what methods have succeeded in connecting members with media efforts. He also asked what lessons can be learned about messaging about the ACA, and what can be applied to the NPS. Mr. Novelli acknowledged that while there is no substitute for professional advice, people are rarely in touch with their clinician. He noted that doctors and other health care workers can be credible message sources for media.

Dr. Swider asked about using evidence-based ways to deal with messages at the environmental level. Mr. Novelli responded that it is necessary to work on normative expectations. Media and policy are huge influences of normative expectations. He used the example of physicians' screening for blood pressure, and while it's important that this became a regular practice by physicians, its equally important that people came to expect to have their blood pressure taken, and question when it wasn't taken.

Dr. John Seffrin stressed the importance of messaging and how it is necessary to couple messaging with what issues are hot. He proposed three messages. The economic loss associated with chronic diseases will be almost $47 trillion, over the next two decades, if we don't intervene. Dr. Seffrin asked if it is possible to couple the notion of economic value with good health. Second, Dr. Seffrin asked if we could talk about taking pride in the country and maintaining competitiveness. Third he asked about the power of choice. In particular, he stated, we can choose to age and be productive or we can choose to age and be disabled. Mr. Novelli responded by saying that every notion that Dr. Seffrin brought up is testable and the U.S. should be building messages around these kinds of appeals.

Dr. Levi asked if the media campaign should be national or more targeted. Mr. Novelli felt it may be appealing to start nationally, however the campaign should start with testing, piloting and tying in with what is being done in the community transformation grants communities, Massachusetts, and other places .

Dr. Van Horn noted that at some point we need to take action beyond calling for good research. Mr. Novelli responded that evidence-based research as well as trial and error can be appropriate. Mr. Novelli suggested we start with what is known and what has been tested using evidence-based research. Dr. Van Horn added that the problems in society are exponential and the research cannot keep up.

Dr. Johansson asked how Mr. Novelli sees the education system playing a role in the strategic plan. Mr. Novelli would put a high priority on the whole academic system, including higher education, and added that elementary, middle and secondary schools should be included - therefore teachers should be a primary target audience.

Dr. Rosenstock asked how to package the high bar for evidence-based prevention research and economic value of prevention interventions. Mr. Novelli responded by saying that mass media campaigns are as much art as science and we will need to experiment to determine what works and to be able to defend our actions.

V. PREVENTION AND INTEGRATIVE HEALTH WORKING GROUP: DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ACA IMPLEMENTATION PANEL

1:00 P.M. – 2:30 P.M.

- Andrew Rein, Associate Director for Policy, CDC
- Lee Wilson, Division of Public Health Services Director, ASPE
- Jim Scanlon, Deputy Assistant Secretary for Planning and Evaluation, ASPE (unable to attend; Amy Nevel presented in his place)
- Anand Parekh, Deputy Assistant Secretary for Health, OASH
- James Hester, Senior Advisor, Center for Medicare and Medicaid Innovation

Dr. Levi reminded the Advisory Group that the working group on Prevention and the Affordable Care Act narrowed their focus to two key activities currently active at HHS, 1). The essential health benefits and 2) population health and prevention activities opportunities through the Center for Medicare and Medicaid Innovation.

Mr. Andrew Rein explained the four prevention pillars of the ACA: preventive services without cost sharing (where community preventive programs educate people and connect to clinical service); policies and programs; Medicare health risk assessments, and community health needs assessments required to be completed by hospitals to maintain their nonprofit status. On the last pillar, CDC has been working with partners within HHS and outside of and with the Treasury Department to come up with best practices in community health needs assessments.

Mr. Rein explained that through the Prevention and Public Health Fund (PPHF), HHS and CDC utilize a three pronged approach to implementation: 1) empower communities to prevent the leading causes of death, 2) strengthen central public health detection and response services, and 3) provide information for action. Mr. Rein emphasized that HHS is seizing opportunities to connect clinical care and community preventive services in order to realize maximum benefits. He noted several programs that exemplify this effort:

- *Community Transformation Grants* empowering over 120 million Americans to make good prevention choices for their communities in terms of tobacco, physical activity, nutrition, and blood pressure control.
- *Pharmacist program* working in conjunction with the Community Transformation Grants pharmacists educate patients on blood pressure control and adherence to medication.
- *Million Hearts Campaign* to prevent 1 million heart attacks and strokes within five years.

The PPHF is also working to produce information for action by understanding the health and health seeking behaviors of Americans that will help to maximize the health value of all healthcare dollars spent.

Mr. Lee Wilson explained that the HHS Secretary is required to define essential health benefits to be covered by insurance exchanges at the state level for the small employer and individual markets. These essential health benefits would also be required for those who are newly eligible in Medicaid. The estimates of people affected range from 35-90 million. The legislation requires these essential health benefits cover 10 categories including ambulatory care, pharmaceutical services, imagining, pediatric care, mental health and substance abuse and rehabilitative services. The guidance to the Secretary can be broader than these 10 categories. The Secretary must relate the essential benefits to the coverage found in a typical employer plan. Essential and typical are related but HHS is finding that some essential services have not been typical, such as pediatric dentistry. Additionally, the Secretary is required to ensure there is balance across the categories and that there isn't discrimination among categories.

The Department of Labor is assessing what is offered under typical employer plans. There is no clear definition of typical. The Department of Labor study looked at what plans offer through their brochures which are not often specific about whether different procedures are covered. Where the brochures are silent on an issue, the Department of Labor couldn't draw a conclusion on typical. Therefore HHS is collecting additional information and working with insurance companies to identify those procedures that are or are not covered.

An important consideration is whether the typical employer plan should include what is offered by small employers or large employers. The Institute of Medicine (IOM) has a report that will outline a process to decide what's in and what's out of essential benefits. The goal is to have a Notice for Proposed Rulemaking released before the end of the year (2011) providing an opportunity for public comment with the final rule to be released mid to late 2012.

Next, Amy Nevel introduced herself representing Jim Scanlon. She noted that Dr. Glied, HHS' Assistant Secretary for Planning and Evaluation (ASPE), is interested in how the ACA's implementation falls within the broader context of the HHS, how these efforts align with the HHS strategic plan, how HHS can craft a modest research agenda to answer questions that emerge, and ultimately advise the Secretary on relevant matters.

Dr. Levi asked whether there will be an actuarial exercise to document cost once the list of essential health benefits is compiled. Mr. Wilson responded that the Office of the Actuary at CMS will make a statement that the recommendations meet the standard of the ACA. HHS predicts it will be a balancing act between what is paid for by the Federal budget, individual premiums and state absorption of the Medicaid population.

Mr. Wilson indicated that direction to engage the Office of the Actuary came from the legislation and the IOM process is objective, informed by science and the field. A number of representatives on the IOM working group represented fields singled out within the ten essential benefits categories (included in the legislation) as well as representatives from the economics and insurance fields.

Ms. Otto asked if CMS will be charged with framing what will be covered under the essential benefits based on the IOM report. This is the responsibility of the Center for Consumer Insurance Information and Oversight (CCIIO).

Ms. Otto asked whether CCIIO will be examining which states already mandate coverage. Mr. Wilson responded that all mandates have been catalogued noting that some mandates, based on cost, will be removed because federal legislation supersedes the states mandates.

Dr. Bigby asked Mr. Wilson to reflect on how he thinks states will maneuver their decisions on what to do with people up to 200% of the Federal Poverty Level and to discuss the potential timeline of the final rule. Mr. Wilson responded that the final rule will not directly affect what happens in Medicaid other than implications for the newly eligible population, who would be covered under the exchanges. He could not speak to what states are going to do from 130%-200% of the Federal Poverty Level. The timing of the final rule will be no earlier than May or June, 2012. He anticipated that there will be a lot of public comments on every facet of what is released in the Notice for Proposed Rulemaking and the final rule. It is expected that once the rule is released states will have a certain amount of time (months) to build and cost out their plans. States will have exchanges to operate and in the instance of states not currently working to building exchanges the Federal government will have to operate exchanges in those states.

Dr. Levi asked if HHS is also addressing who provides the benefits. Mr. Wilson responded that ASPE has not been involved in discussions about what kinds of providers provide which services. ASPE's focus is the actual services provided.

Dr. Levi asked whether the Secretary could reduce cost sharing requirements. Mr. Wilson responded that this is a possibility.

Ms. Brown noted that in looking at how these exchange programs manifest themselves by locality, there may be more demand than supply, such as with low income women wanting reproductive services but lacking doctors to provide these services. She asked how ASPE is assessing this as they roll out the new program.

Mr. Wilson responded that Dr. Glied is leading a group to identify data points that can be collected to see what changes behavior, what outcomes exist and what externalities need focus. HHS is building a system to track the results of the legislation. Ms. Nevel added that another project will develop a series of papers on issues that frame prevention in all the markets across the country, such as where people go for health services. Dr. Levi requested a list of the papers that have been commissioned and some additional information about this project.

Dr. Bigby suggested that as the Prevention Council works across agencies they should look at these categorical programs to see if they can be expanded to become more comprehensive primary care or prevention programs. Mr. Rein noted that categorical funding has always been a challenge and that, consolidated chronic disease grants have been released to facilitate states integration of their programs on a risk factor basis rather than a disease basis and facilitate an efficient patient-centered program.

Dr. Levi stated that Dr. Bigby's suggestion is that following the creation of an essential health benefits package there may be available providers, if certain programs are reframed, and the challenge is for HHS to reach out to these providers and entities before they disappear.

Mr. Wilson indicated that ASPE has begun a review of large funding categories to make sure that necessary services do not disappear, determine how to appropriately reallocate savings that emerge and make sure the health care system continues to be comprehensive.

Dr. Seffrin inquired how many more people have insurance since grown children can remain on their parents' insurance plans until they reach 26. Mr. Wilson offered to provide an answer to this question following the meeting.

Ms. Brown noted that before health care reform there was a huge deficit of primary care physicians in rural counties in the U.S., which make up 70% of all U.S. counties. She noted that some rural residents have to travel more than 200 miles to access a doctor. She inquired as to how these needs will be addressed. Mr. Wilson noted that HHS is working to identify ways to increase supply of primary care doctors, increase the ability for professionals to operate at the maximum scope of their training and attract more people into primary rather than specialty care. The Secretary and the White House are also discussing that initiative. HHS analyzes where there are providers and where there are shortages. There have been efforts to redefine HPSAs (Health Professional Shortage Areas), however, he noted that if nurses are counted differently some areas would no longer be considered HPSAs, and communities do not want to be removed from this list. ASPE has also looked at utilization of care by individuals not covered in order to better be able to anticipate the increased demand for services that may occur.

James Hester noted that questions about provider capacity have been a major issue for CMS. He noted that CMS has a series of initiatives in primary care medical homes, Federally Qualified Health Centers and state multi-payer initiatives. He asserted that this is a serious issue and one that the Center for Innovation, in cooperation with many others, is working to address.

Dr. Mayer-Davis inquired about the process for identifying what procedures will be included in the essential health benefits packages. Mr. Wilson responded that the process is on-going and once defined there will be a body who considers how to proceed, whether more evidence or issues have emerged and whether there is conflict across the various categories. HHS has a continuum of approaches for addressing this: the extreme is to provide the ten categories loosely and let people define them, and the opposite extreme is to reconstruct the Medicare approach. He anticipates that ultimately the approach will fall somewhere in the middle, but figuring out specifics will be the responsibility of the aforementioned body.

Dr. Johansson asked what kinds of advice or resources will be available for rural hospitals to conduct community health assessments. Mr. Rein responded that there are not specific resources dedicated to this type of technical assistance, but a best practices document is in the works that provides space for various stakeholders to offer input, guidance and efficiencies to prevent duplication of efforts.

James Hester noted that he would provide context to the work currently being accomplished by the Center for Innovation. The Center for Innovation was established by the ACA (under Section 3021) and was granted $10 billion in funding through Fiscal Year 2012. The Center for Innovation combines the work of the old Medicare Demonstrations Group and the Office of Evaluation and much of the work focuses on prevention initiatives. It aims to identify, validate and diffuse new models of payment to improve health and health care and reduce cost of care. It has established three measures of success: better health care in terms of services provided to patients in need, better population health by addressing the social determinants of health and reduced cost. The Center for Innovation's strategy is also threefold: testing new payment and delivery models, diffusing what works, and trying to foster new ideas. The process the Center for Innovation is using is to elicit ideas on models to be tested, select the most promising models; test and evaluate models using a rapid cycle that gets incorporated as part of the feedback, and spread successful models. The Center for Innovation is putting in place this basic cycle for all of its initiatives.

Dr. Hester emphasized there is a wide range of organizations with whom the Center for Innovation collaborates, including the private sector. The Center for Innovation solicits input on how the population health model can do its work. Mr. Hester emphasized that the Center for Innovation invites the Advisory Group to submit suggestions and ideas of promising models for future focus.

Dr. Hester explained that the population health model successfully launched under Anand Parekh, Deputy Assistant Secretary for Health, contains general disease-specific interventions aligned with the major causes of death as laid out in the NPS and geographically-focused interventions that are not disease-specific. These interventions would create a horizontal infrastructure within communities to improve health.

Anand Parekh, noted that there is now an opportunity at CMS to improve public health through prevention. He reiterated that the purpose of the population health model is to improve health of a population with a focus on prevention. Dr. Parekh believes there are opportunities to branch out to other social determinants of health as laid out in the NPS and that there are opportunities for CMS to be more creative.

Dr. Parekh is trying to understand levers, what the payment delivery chain allows for and how to make sure that multiple efforts align and is looking across departments and to external groups to where there are opportunities to add value. He emphasized that data is critical in the decision making process to ensure that the agency invests resources where data are generated. Models that are tested can only be scaled if health outcomes improve.

Dr. Bigby inquired about the relationship between Medicaid and Medicare and how those two programs align to the work of the Innovation Center. The Center for Innovation is examining how every decision would affect Medicare and Medicaid beneficiaries and the relationship between care initiatives is being closely integrated.

Dr. Mayer-Davis noted that the childhood obesity programs that are effective are multi-level and multi-component. She asked how the Center for Innovation works with other agencies that would be important to partner with in order to implement a model that is multi-level and multi-component. James Hester asserted a commitment to a multi-sectorial approach despite being more complicated to implement.

Ms. Otto noted CMS effectively implemented a multi-sectorial approach when it worked with SAMHSA. She asked whether CMS is building any requirements for sustainability planning into grants coming out of the Center for Innovation. James Hester clarified that the Center for Innovation is developing and testing payment models that can be sustained over time and not offering grants. CMS is committed to transformational change which is why it emphasizes multi payer initiatives. Dr. Parekh clarified that states are working with the Federal government. If a state's model demonstrates cost savings then states will continue to operate with that model. Barbara Otto noted that sustainability could come in the form of resources and leadership. She would like to see leadership and buy-in at high levels of government as the states proceed to build their models.

Dr. Murthy noted that he would like to understand what level or groups are being targeted by the population health model and how CMS plans to target these levels. James Hester noted that CMS has cast a broad net to promote messages to a wide range of audiences and provide guidance; increase the cadre of people doing population health and explore ways to support manpower and development. In addition to large scale testing

of models, CMS is asking what role it can play to support innovative development within the culture of health care.

Dr. Johannsen asked which strategies the Center for Innovation is using to eliminate health disparities. Dr. Hester noted that currently, information for the Pioneer ACO program includes guidance for applicants that provide services to more complex populations. He said that CMS has a long way to go but will begin to align more specifically with the population health model. He believes that achieving outcomes requires reducing disparities. Hester explained that CMS would like to incorporate more explicit measures related to this in the future and that the Advisory Group should send any related suggestions.

Dr. Bigby noted that Massachusetts' Medicaid coverage of smoking cessation is a much wider benefit than delineated in the ACA.

VI. PREVENTION AND INTEGRATIVE HEALTH WORKING GROUP: RESILIENCY AS A KEY CONCEPT IN PREVENTION AND HEALTH 2:30 P.M. – 4:00 P.M.

- Wayne Jonas, President/CEO, Samueli Institute
- Colonel Christian Macedonia, Medical Sciences Advisor to Chairman, Joint Chiefs of Staff, The Pentagon
- Terri Tanielian, Senior Social Research Analyst and Director, Center for Military Health Policy Research, RAND Corporation
- Dr. Bezold, Founder and Chairman of the Board, Institute for Alternative Futures

Wayne Jonas, President/CEO, Samueli Institute explained that he would be expanding on the definition of prevention in health promotion. Jonas has put together a group to address the issues around prevention and prevention of disease and decide where the focus should be for the field. Primary prevention cuts across the continuum of health including psychological resilience, social aspects, environmental toxins, exercise and rest. These 'wellness approach' concepts are fundamentally different than the typical medical approach that emphasizes treating diseases. Resilience is the idea that human beings and communities can respond and recover when stresses occur.

Terri Tanielian, Senior Social Research Analyst and Director, Center for Military Health Policy Research, RAND Corporation, explained that the past ten years have placed strain on U.S. military forces. The Department of Defense (DOD) wants to protect service members and their families from strains of war and has tried to understand why some service members do well and some don't do well. DOD's goal is to identify and promote factors to help the armed forces withstand the stress and strain they face.

The key concept of resilience is that individuals, in the face of adversity and risk, can adapt and thrive and that there can be post-traumatic growth back to and beyond the baseline.

DoD has a number of programs that contribute to and promote resilience at different levels: individual, family, unit and community. Factors that influence individual resilience include affect, realism, positive coping strategies, sense of self efficacy, ability to monitor and regulate and altruism. Family and emotional ties are important because they can help the individual feel supported and nurtured. Supportive leadership and

command can help the unit endure stressful situations. On the community level, individuals can feel a sense of belonging, cohesion and community self-efficacy. Individuals in a community can work together to rebuild and support each other. Colonel Christian Macedonia, Medical Sciences Advisor to Chairman, Joint Chiefs of Staff, The Pentagon, introduced himself and introduced the concept of "Total Force Fitness." Total Force Fitness is a doctrine signed by the outgoing chairman, Mike Mullen, who wanted to talk to medical professionals about the concepts of health and resilience.

Mullen and Colonel Macedonia realized a framework was needed to facilitate a dialogue with the medical community and stakeholders. The Pentagon, engaging Mr. Jonas, the Uniformed Services University and advisors from the civilian community asked stakeholders to explain how they defined fitness and to discuss their conception of mind-body duality. The Total Force Fitness model grew out of these conversations.

Total Force Fitness has eight integrated pillars. The total force fitness model focuses on leaders in the military and in communities. There are three layers inherent in Total Force Fitness: family, community and organization. Family is the cornerstone of individual fitness and family doesn't have to be nuclear family.

Total Force Fitness is in its beginning stages and will guide the DOD in its goals to pare down and set common terms of reference for service members.

Dr. Bezold, Founder and Chairman of the Board, Institute for Alternative Futures, explained that he focuses on community resilience. Working with communities hit by disasters he supports the implementation of community-based decision processes and helping communities look at the future.

Dr. Bezold explained that communities around the country, known as transition communities, are building resilience by lowering their carbon footprints. Communities are also coming together to solidify their vision, aspirations and identities. An example of community resilience can be seen in Galveston, TX, which was hit by Hurricane Ike. During the rebuilding process, leaders in Galveston produced a series of goals which included analyzing food deserts and rebuilding public housing in a smarter way. In general, community resilience tools and approaches recognize the social determinants of health and allow communities to address immediate and long-term challenges.

Ms. Brown inquired about the data available to support the relevance of these resilience factors and the metrics that exist to measure this model. Ms. Tanielian responded that the literature speaks to this question. There are certain individual traits that lead to resiliency but there are also processes documented in the literature that individuals can learn that can contribute to resiliency. However, some resiliency research is not empirically based and few studies have been done to see whether implementing certain interventions bring about change. Researchers are now in the early process of conducting assessments to observe whether or not factors and programs designed to modify some of these factors that lead to increased resilience are effective.

Colonel Macedonia responded that the total force fitness framework includes 10 pages of suggested metrics as a core part of the doctrine is measurement and reporting.

Dr. Levi noted that an IOM committee has started working on how to define value in community prevention, and specifically, how to measure success and present it to policy makers.

Ms. Brown suggested that communities should change their crisis management approach to disaster planning. She noted that local governments around the country are currently dealing with service members returns and because of this influx, developing a cooperative mentality between local government and military would be

helpful. Colonel Macedonia acknowledged the point and said that the military cannot dictate actions to communities and can only suggest courses of action.

Dr. Levi wondered whether there is a way to promote community resilience for communities that do not suffer from trauma or disaster and specifically whether community resilience can be incorporated as a way to build healthy communities.

Dr. Bezold clarified that communities do not need disasters to incorporate the concepts of resilience. There can be ongoing community projects to address the social determinants of health and create futures movements.

Dr. Levi noted that the committee previously discussed messaging and how to communicate messages about health to the public. He noted that Colonel Macedonia encouraged messaging to be targeted at leaders rather than the community. He asked Colonel Macedonia to explain how he would define leaders that need to be reached in the civilian community where leadership may be less obvious than in the military community.

Colonel Macedonia noted that leaders can be both traditional leaders, thought leaders, or people that are respected as role models. Social media was noted as an important source that can connect messaging with leadership. Social media inherently expands idea of what community leaders and community means—many people find community on the web. It is still important to reach traditional media outlets but social media is useful especially to influence youth.

Ms. Tanielian noted that effective messaging is about figuring out who has contact with individuals and influences them on a daily basis.

Mr. Jonas remarked that the Advisory Group has the opportunity to contribute substantially to national leadership because the council is made up of people leading huge policy efforts.

Dr. Johannson noted that the issue of resilience is frequently discussed among American Indian and Alaska native populations.

Sister Kerr inquired whether the IOM committee will be taking into account this material on community resiliency. She reiterated that the time is now to integrate these ideas into our policy decisions. Wayne Jonas agreed that the Advisory Group should emphasize to the Council the importance of focusing on health and not health care. Dr. Bezold wondered what the role of health care providers should be, suggesting that providers should theoretically write prescriptions for healthy homes and physical activity.

Dr. Levi encouraged the Advisory Group not to dismiss the ways in which the ACA can improve the medical system, and to think in a more integrative way about how to broaden access and coverage. Mr. Jonas suggested that a useful exercise may be to examine how health employers look at health promotion, since many of these employers have realized that if their workers don't live in healthy communities they will not be healthy.

Dr. Murthy drew a parallel to the business world, where businesses have begun to create a culture of greater self-efficacy by defining core values. He inquired as to what Mr. Jonas' vision is about how the resiliency approach could unfold outside of the military.

Mr. Jonas responded that increasing the dialogue between businesses and communities would be a good place to start. Developing or finding an approach or framework to link community activities to policy would also be useful. Dr. Bezold echoed that the concept of wholeness is very important—asking the community for their important goals and undertaking activities that can create a sense of wholeness that comes from pursuing shared values aggressively.

VII. PUBLIC COMMENT PERIOD 4:00 P.M. – 4:30 P.M.

Four members of the pubic provided comments. Each was given three minutes to speak. The following table summarizes their comments.

Speaker	Organization	Summary of Comment
Janet Kahn	Integrative Healthcare Policy Consortium and Consortium of Academic Health Centers for Integrative Medicine	Dr. Kahn first commented on the presentation on resiliency. Her organization has worked with veterans on the Missionary Connect project. She said that the concept of resiliency should be taken at the organizational level. It is a question of variability whether the organization can respond to the environment. This poses a challenge to figure out how to allow for community-to-community adaptability. She sees incredible opportunity within the ACA. She is concerned that those addressing one section of the ACA are not taking into account other sections. For example, Section 5002 expands the definition of AHECs to include "universities or colleges not operating a school of medicine or osteopathic medicine." Section 5001 provides an expanded definition of the national healthcare workforce. However, the national healthcare workforce was not appropriated any funds. There is no one able to argue for the expanded definition. But this has merit and there are aspects of the healthcare workforce that could be deployed.
Helen Luryi	National Partnership for Women and Families	Ms. Luryi commented on two areas—promoting access to quality health care and promoting policies allowing workers to take care of their families. She said that good workplace policies could promote access to care. While there are many employers that offer paid sick leave, this voluntary business practice is not enough. The issue of lack of sick time disproportionately affects low-income and minority populations. Without time to see a primary care provider, patients must use the emergency room. Paid sick days could save $100 million per year. She asked that the Advisory Group think about the ability to take time off from work to access care as important to health. She added that she is excited by the opportunity with the Community Transformation Grants and hoped that grantees would address public policy, system and environmental changes.
Melissa Merson	National Coalition for Promoting Physical Activity	Ms. Merson is the new Executive Director of her organization. She noted the National Physical Activity Plan was developed by her organization. The plan is a public-private collaborative. She said that there is no need to reinvent the wheel, as a comprehensive resource

Speaker	Organization	Summary of Comment
		already exists. The plan aims to create a national culture to support physically active lifestyles. It includes recommendations for eight societal sectors (health care; public health; education; business and industry; mass media; parks, recreation, fitness and sports; transportation, land use and community design; and volunteer and non-profit). These sectors are engaged across all levels. Guiding principles include the use of evidence to inform the Plan's actions to promote physical activity; initiatives for all socio-demographic groups, action at local, state, federal, and institutional levels; involvement of diverse stakeholders; grounded in the ecological model of health behavior; initiatives that reduce health disparities across socio-demographic groups; and presentation as a "living document" that is updated on a regular basis.
Daniella Gratale	Nemours	Ms. Gratale spoke about improving the health of all children, through clinical and community services. Nemours has a prevention branch in Delaware. The main issue is childhood obesity. They are using multi-sector engagement—including schools, community-based organizations, primary care and others. She noted CMMI as an opportunity to advance payment and delivery reform. She said it was important to bring together the work of CDC and CMS in geographic communities. Clinical services and community-based services are siloed. Community-based services and clinical services should be brought together to improve the health of all. She hopes the Prevention Advisory Group will work with CMMI and CDC. She encourages them to work together and leverage funding streams.

VIII. OBSERVATIONS OF THE DAY 4:30 P.M.-5:00 P.M.

Mr. Helms stated that while the healthcare system is grounds it's practice in science, estimates suggest up to 40% of the services provided are not necessary. Within public health more focus on metrics or proof of concept is needed. He is delighted that the National Prevention Council exists. He is not sure if they would be successful as an Advisory Group if they follow the role of other Advisory Group. They need physicians out talking about the ACA in a way they have not before. Maine is training 600 physician leaders to talk about the health system in a new way using a state of well-being definition. He urged the group to think about what they have to do to break the mold.

Dr. Swider found this to be a thought provoking day and suggested that the recommendations made be phased out in short-term, medium-term and long-term objectives. They should grasp the idealized vision of where they need to go, but may be destined for failure because it is too far out. They need short-term, concrete, achievable things.

Dr. Murthy highlighted the session on communication and messaging. He said that part of the purpose of the Advisory Group is to be a connection to the outside world. He thought it was important to be a part of the messaging campaign, which should be a priority.

Dr. Mayer-Davis said that the tendency is for groups to end up in polarized discussion of health versus healthcare or health versus anything else. She hopes the Advisory Group does not fall into that trap as there is progress and accomplishment and good to be had from any and all of the above. She cautioned the Advisory Group about their dialogue and to be wise enough to have the courage to not get into trap.

Ms. Otto highlighted the presentation by Colonel Macedonia which promoted a doctrine, not a program. She said that social determinants of health could be put into a doctrine and noted the use of a metrics tree. This would allow communities to track within and across communities and would fit into a larger picture of a doctrine. She said that the other piece is the public-private partnerships. They cannot get very far without partners in the private sector, thought leaders, and new forms of media.

Dr. Bigby agreed with Ms. Otto that the group should not lose sight of opportunities within the framework of health and healthcare. There is an opportunity to improve people's health through the ACA. She wants to ensure that, given this opportunity, real outcomes related to health promotion are made. The healthcare system is a series of concentric circles that the National Prevention Strategy is trying to affect. She noted the magnitude of outcomes that the National Prevention Strategy is addressing. She agreed with creating short-term goals and objectives.

Dr. Binder said that practitioners are a strategy. He asked who is developing tactics for implementation and who is going to integrate the community health provider into developing preventive medicine policies. He was concerned about a discussion focused on strategy, but not tactics.

Dr. Seffrin suggested the AG be deliberate, but also make progress sooner rather than later. He said it was important to create a sense of urgency. The AG needs to design something with the centerpiece being prevention. The global community has recognized NCDs as the most pressing issue. There are thirteen pages of a political declaration that say first NCDs will be the health disease disability challenge of the 21st century. Second, they need to know what they need to do. And third, they have to be multisectoral. The private sector needs to get involved. The NGO sector could advocate, build capacity and collaborate. He said that the Advisory Group needs to think about how to keep this on the front burner.

Dr. Levi suggested the group leave the day with an optimistic outlook. All members of the Advisory Group are presidentially appointed. And as a result, have a voice. The Advisory Group has to be very focused. He noted the importance of Dr. Seffrin's comment about the UN conference, as well as the discussion of community interventions and the move from public health to mainstream. He concluded by stating that the Advisory Group needs to deliberate about what will be the focus.

Dr. Murthy agreed with Mr. Helms. He said that they do not want to be just an Advisory Group, but want to have an active role in implementation. He suggested the Advisory Group spend time discussing how to optimize their function as a group to function more synergistically. He said that they need to know about each other's experiences and should do more sharing around their experiences.

Dr. Levi adjourned the meeting for the day.

Tuesday, October 4th

IX. WELCOME AND REVIEW FROM DAY 1 — 8:45 A.M. – 9:00 A.M.

Roll was taken. Barbara Otto joined by phone. Dr. Rosenstock was absent. All other members of the advisory group were present.

Dr. Levi thanked the group for the previous and current day and laid out his vision for a three by three table to sort out what was heard. On one side, the Advisory Group is trying to communicate with three groups: key policy makers, the National Prevention Council through ongoing engagement, and constituencies, in terms of how to spread the word to their constituencies and how to build the constituencies. The other side of the table is what they are trying to influence: who they are trying to influence and what, quick wins which they can help spur along that will keep momentum of the National Prevention Strategy going, and non-HHS organizations that need positive reinforcement. He said that all fits into the long-term vision and change. He suggested this as one framework to understand how the pieces fit together.

Dr. Levi acknowledged the members of the Engagement Working Group, which include Ms. Brown, Dr. Fielding, Mr. Helms, Dr. Johansson, Dr. Mayer-Davis, Ms. Semonoff, and Dr. Swider.

The charge to the working groups was to identify steps to make a case and statement for a prevention focus, build constituencies in the 17 agencies represented in the National Prevention Council, reinforce commitment to these issues, and identify opportunities for the group and individuals to build relationships with these agencies. He said that the day would consist of a discussion regarding the National Forums, other engagement potential and the use of Health Impact Assessments (HIA) as a tool to build a culture of health in all policies.

Dr. Levi noted that there is no time limit in the charter for the Advisory Group. They serve the pleasure of the President. Dr. Benjamin said that there is an expectation that the Advisory Group will be around for a long time because of the requirement that they meet every year. The advisory group is planting a foundation. She was optimistic that they would be around as structured.

X. NPS – REGIONAL FORUMS AND ENGAGEMENT WORKING GROUP: OPPORTUNITIES FOR ACTION — 9:00 A.M. – 10:00 A.M

Dr. Lesley Russell, Senior Public Health Advisor for Outreach and Policy, Office of the U.S. Surgeon General, presented on the National Forums. Dr. Russell explained that that the National Forums will focus on three activities; however these activities may be expanded over time.

- First, education and awareness among stakeholders to build knowledge about the National Prevention Strategy.
- Second, galvanizing action so that the Advisory Committee can begin to deliver on their goals and targets.
- Third, highlighting some of the issues that are already being addressed to show that progress is being made.

Dr. Russell explained that HHS has ten regional offices around the country. Some of these regions have already implemented regional level Prevention Councils, and the aim of the regional meetings will be to create National Prevention Councils and Advisory Groups in all regions. The Office of the Surgeon General would like to hold eight or nine of these meetings within the next 12 months. .

Planning for the regional meetings is still in the early stages and the Office of the Surgeon General (OSG) has drawn up a set of criteria but has not yet planned where all of the meetings will take place. The two key drivers to planning the meetings are the Surgeon General's schedule, and the desire to showcase success stories, rather than to focus on areas with large gaps. The Office is planning on holding meetings in Chicago and North Carolina prior to Christmas, and there is a tentatively scheduled meeting in San Francisco for February 2012.

In planning each regional meeting, the Office will contact the HHS regional office, as well as local organizations. OSG has already developed a list of the types of individuals and organizations that should be invited to each meeting, including local regional representatives, directors of federal agencies, state and local officials, academics, representatives from communities of faith, and local prevention councils and grantees.

The Surgeon General will plan to convene the first round of regional meetings; however Dr. Russell noted that the meetings are not only an HHS initiative, but involve all of the stakeholders of the National Prevention Council, therefore for future meetings OSG will encourage other senior members of the administration to take over this role. . Dr. Russell has worked with Dr. Levi to identify those who have expressed interest in generating work with local stakeholders including providing funding or technical assistance for grants. Dr. Russell noted that communities do not need large Community Transformation Grants to take action, as there are plenty of examples of communities implementing simple interventions that are not resource intensive.

Dr. Russell provided an overview of Community Commons, a project creating a virtual network of individuals working on community prevention. Community Commons consists of several parts, including an interactive map that shows resources such as health departments, schools and transportation. It also highlights ongoing projects and their respective funders. Community Commons is working to set up a community messaging exchange, allowing individual project groups to create their own websites to post and share documents with other groups. Dr. Russell noted that resources such as these are incredibly important to allow communities to take action.

Finally, Dr. Russell mentioned how enthusiastic the U.S. Public Health Service Commissioned Corps is about these initiatives. The Commissioned Corps is divided into 11 groups by profession—physicians, nurses, pharmacists, dentists, dieticians, engineers, environmental health officers, health services officers, scientists, therapists, and veterinarians. In addition, there is a Medical Reserve Corps, which is part of the ACA. All together, the Public Health Service has over 200,000 volunteers and includes about 9% of the population and 7% of the country. All of these groups are eager to work on implementing the National Prevention Strategy. The Surgeon General is working to find ways in which the Public Health Service can help.

Dr. Levi commented that Dr. Swider and Ms. Otto had engaged in outreach activities at the state and local levels to generate interest in the Chicago and North Carolina regional meetings. Chicago has created a "Healthy Chicago Strategy" similar to the National Prevention Strategy. He added that the regional meetings

will be used to catalyze interest in these efforts. Dr. Levi also noted that one funder, the Missouri Health Foundation, has discussed using the National Prevention Strategy to guide grant making. He concluded that there are opportunities for using the National Prevention Strategy to create change in ways that may not always be measurable.

Ms. Otto noted that in every community, especially in Chicago, it will be important to assess what already exists. She commented that she is aware that the HHS Region 5 Director is interested in working together, so she and Dr. Swider would be willing to start an analysis of what programs exist in the community. She feels that this may help with the sustainability issue. Ms. Otto also noted that Chicago is extremely political and does not often work with the state of Illinois and that the Office of the Surgeon General will have to work to bring them together. Dr. Levi suggested looking at the Community Transformation Grants, and Dr. Russell suggested the Advisory Group look on Community Commons as they may be surprised about what already exists.

Ms. Otto wondered who will be responsible for continuing the initiative after the first round of regional events, noting it would be important to get buy in from main line organizations. Sister Kerr suggested that they focus on grassroots efforts. She suggested OSG create a grassroots framework to educate people on the ground. Dr. Fielding raised three issues. He noted that it is important to have meetings that are convened by other sectors and not just health. He also mentioned that he met with ASTHO and that they are interested in participating in the regional meetings. His third issue was in reference to developing an evidence-based database. Dr. Fielding circulated a DRAFT report for the Community Preventive Services Task Force. He suggested that the report is a resource that could provide the beginning of the evidence-based data base.

Mr. Helms pointed out the amount of attention that is being given to the ACA. He said that current conversation about prevention is revolutionary in terms of how the federal government is talking about health and well-being and that it is a long term process. He commented that as an Advisory Group, they should think about what they can do to create long-term, meaningful reform and to disseminate information. He noted that Dr. Don Berwick, CMS Administrator, said the ACA was a magnificent piece of legislation and that prevention is an under-sung portion. Mr. Helms urged the Advisory Group to determine how to drive that message.

Dr. Levi suggested transitioning to what the Advisory Group can do in their communities. He said that Dr. Benjamin does not have to be the only one engaging in these activities. Many leaders in the federal government can do this. He suggested that a federal official visit each of the communities with Community Transformation Grants to jumpstart and bring attention to these initiatives. Dr. Benjamin suggested the 17 National Prevention Council members lead those both with and without her. Ms. Brown referenced the discussion of building regional forums around stories. She noted that counties are facing reduced funding. For example, Ms. Brown's county said that 55% of revenue comes from the state and federal government to provide services asked by the state and federal government. However, because of low resources, they had to rethink how they address the community with regard to evidence-based programs. It requires upstream investments by talking to community non-profits and addressing what evidence-based programs can be used to achieve a quicker outcome. Ms. Brown urged that the Advisory Group take action, and not rely on a federal official.

Dr. Levi said that nothing prevents the members from speaking out as individual members of the advisory group. The question becomes what resources are available to make that task easier. He suggested sharing a slide deck from Dr. Graffunder that can be used to talk about the National Prevention Strategy.

Dr. Graffunder responded that she could make a slide deck available and reminded the AG that they would be acting as individuals, not as a body. She also noted that, outside of the Advisory Group, CDC has put resources into ASHTHO and NACCHO to help with their work. These could be hubs to gather information. Dr. Benjamin suggested sending stories to Dr. Graffunder's office.

Dr. Van Horn said she would represent the National Prevention Strategy Advisory Group to organizations in North Carolina. She said that the members think about the Strategy all of the time, but they have to get ordinary people thinking about it.

Dr. Binder stated that they are addressing receptive audiences and need to identify non-receptive audiences. Dr. Fielding wanted to emphasize Dr. Binder's point and suggested a universal approach that is essential to complement the healthcare system. The country is spending more on health than it can afford and not receiving the benefit. This is a unifying approach that involves businesses, voluntary organizations and civic organizations and should be put into the context of having universal appeal. He said that it is important to have different agencies and sectors involved. The question is how to get broader organizations, such as a chamber of commerce, to be a sponsor.

Dr. Murthy discussed the points regarding the sense of urgency. He supported the idea of local advisory groups in the context of local leaders as an important complement to existing local groups. The AG members could identify a few key leaders in business, advocacy and social influencers (bloggers, etc.) to involve. He suggested the group utilize resources and pool their connections. Through legislators, community groups and publications, they can help each other get their voices out.

XI. ENGAGEMENT WORKING GROUP: HEALTH IMPACT ASSESSMENT

10:15 A.M. – 11:30 A.M.

Dr. Levi introduced Dr. Aaron Wernham, from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable Trust. He noted that the Engagement Working Group has heard part of the presentation from Dr. Wernham on Health Impact Assessments. The Engagement Working Group was charged with how to integrate the notion of taking a health lens to policy for multiple agencies and noted that Health Impact Assessments are gaining traction.

Dr. Wernham thanked the Advisory Group. He thought the approach of National Prevention Strategy was innovative and said it is a huge opportunity to bring new resources to impact public health. He said that a huge amount of evidence has been amassed over the past 20 years that energy, transportation and other areas can influence public health and that this lead to the question of what could be done on the ground to insert health into a wide range of policy. Dr. Wernham was a family physician and has worked in a variety of settings, from inner city populations to rural Alaska. He said that it felt like he was swimming upstream against social, economic, and environmental conditions. He questioned how to shape conditions where people live and work to support better health and better decisions.

The National Prevention Strategy speaks to this by addressing healthy and safe communities. He questioned what concrete actions could be taken at the federal, state, local and community levels. Dr. Wernham had served on a National Research Council committee to address this question to help decision makers. The challenge is that there is no common language. For example, a transportation planner does not have public health expertise. There is no regular forum for these fields to interact. And there is often incomplete data

about how policies affect health. Health is only one priority in building roads, developing agriculture policy, and other policies.

Health Impact Assessment takes a systematic look at policy. For transportation, it looks at air quality, but also how that affects access to grocery stores and more. Health Impact Assessment uses available methods from multiple sources. It is often qualitative, but also uses quantitative data. Health Impact Assessment is proven to be an effective way of engaging all of the stakeholders. It also ensures that public health interacts effectively with decision makers. Health Impact Assessment provides practical recommendations.

Dr. Wernham spoke to the history of Health Impact Assessments, which grew internationally from different efforts. In Europe, there was an effort to look at the impacts of social policy and the physical environment. Businesses were early adopters and are robust practitioners. The oil, gas, and mining industries are adapting guidance for Health Impact Assessments and implementing it. The World Bank and other lenders have developed standards for Health Impact Assessment. Similar information was presented to the National Prevention Council.

Dr. Wernham said there are three ways federal agencies can take this information and act on it. First, it can be used in agency decision making, such as with USDA and competitive foods. Second, it could be used in federal funding programs, including HIA as a fundable activity to ensure good planning for sustainable communities. Third, agencies can incentivize applicants for federal funds to use Health Impact Assessments or related assessments. Dr. Wernham said his organization is currently able to work with state, local, non-profit partners.

Dr. Fielding commented that Health Impact Assessment is just a concept. He suggested framing the concept in terms of health effects. He noted that there are two types of Health Impact Assessments--maximizing stakeholder engagement and looking at policy. He was concerned that the demand for doing Health Impact Assessment exceeds the supply of competent practitioners. Health Impact Assessments are required as a part of Environmental Impact Assessments but are often not being conducted. .

He emphasized the need to frame Health Impact Assessments as a set of systematic processes. He also emphasized the importance of multidisciplinary teams to conduct assessments.

Dr. Bigby noted conversations regarding the name of the process. She asked Dr. Wernham about the range of cost for a Health Impact Assessment. She also asked if it were possible to describe the impact of cost on outcomes.

Dr. Wernham acknowledged that the name, Health Impact Assessment, will continue to be a liability. They had consulted with several communications firms regarding the name. Because the Health Impact Assessment builds health into the process early on, it helps sell projects to the community. Regarding outcomes, Dr. Wernham noted that there is relatively little academic evaluation of the field. From surveys conducted with CDC and Johns Hopkins, there are concrete changes that can be made in programs that impact health. Comprehensive plans that include health oriented criteria, such as indoor air quality, effects from outdoor air quality, access to parks, are design criteria that are built into the planning stream.

He provided the example of the Atlanta BeltLine Corridor for transit and trails. The Health Impact Assessment showed a clear health benefit for communities in need for safe places to walk. With regard to process outcomes, Dr. Wernham added that the Health Impact Assessment helps develop collaborations. Dr.

Wernham also addressed the question of cost, which includes both staff time and money. He said that a Rapid Health Impact Assessment could cost $5,000 to $10,000, while a comprehensive Health Impact Assessment may cost as much as $200,000. A large plan could require one to two years with full time staff and consultants. CDC funded state health departments to provide training and technical assistance for local health departments. They provided a $150,000 for up to six Health Impact Assessments. Dr. Wernham concluded with two remarks. First, Health Impact Assessment is one of the tools for health officials and should be a part of what is done in public health. Second, he said that Health Impact Assessments could be funded through non-grant resources. For example, San Francisco uses permit fees. He added that it is possible to build partnerships to bring in resources.

Dr. Mayer-Davis asked if social effects are considered for Health Impact Assessment. Dr. Wernham said that they took a broad definition of health outcomes, factoring in social determinants of health, such as community cohesion, social conditions, income, and employment. The frame is health and well-being. While not all high level policy Health Impact Assessments do this, project Health Impact Assessments involve greater stakeholder engagement. He said that local issues are framed for people to understand community impact.

Ms. Brown noted that health is considered in almost all policy decisions in California. The developer of the project generally pays. She was unsure if the objective of Health Impact Assessment was not being carried out in many jurisdictions. She said that the population is interested in health impacts and leaders are cognizant of that. Dr. Fielding responded that California has a Strategic Health Council that advocates for health in all policies. He added that it is important to talk about co-benefits. For example, clean streets are healthy and more attractive.

Dr. Wernham noted the used of permit fees. Health Impact Assessment is not legally required in most jurisdictions. Permit fee agreements have been made through voluntary efforts by developers and the agencies that provide permits. He said that Alaska and other communities have found value in this.

Dr. Levi noted two conclusions. Health Impact Assessment is a new field and a field with limited capacity in terms of trained individuals. Also, he asked if incentives should be provided to build in Health Impact Assessment. Dr. Wernham noted that it should be expressed in an appealing way to systematically consider potential health effects. Dr. Murthy noted the low capacity and community awareness. He asked how capacity is being expanded. He also asked what communities could do.

Dr. Wernham responded that, in terms of capacity, they are doing what they can with the available resources. Some universities are adding courses on Health Impact Assessment. The American Public Health Association (APHA) has a curriculum on Health Impact Assessment. State and local health departments are being trained by CDC and the National Center for Environmental Health. Dr. Wernham's project is training public health institutes. He noted that capacity will continue to be an issue, but was encouraged that it is growing quickly. He also discussed the need to generate community demand. While communities understand how proposals affect them, the challenge is in communication and dissemination.

Dr. Levi provided the members of the Advisory Group with materials prepared by George Washington University that provide an agency by agency look at the responsibilities assigned in National Prevention Strategy. The materials include how health relates to agency's mission, relevant areas, and outreach targets. He noted that the materials have also been posted on the website. He said that they could be developed further if they are of value.

XII. DELIBERATION BY THE ADVISORY GROUP ON RECOMMENDATIONS TO THE NATIONAL PREVENTION COUNCIL 11:30 A.M. – 12:30 A.M.

Dr. Benjamin urged the committee to not allow people to diminish the NPS by concentrating on cost. The NPS is about keeping the nation healthy. Dr. Levi recommended that a working group come together rapidly to write a synthesis of the recommendations that emerge from this meeting. This working group would draft the synthesis report and then the full AG would meet via phone to finalize and transmit recommendations.

Dr. Swider noted Bill Novelli's October 3rd presentation, and emphasized that it is necessary for the Advisory Group to develop a plan for most effectively communicating its message to audiences beyond the "typical suspects". Dr. Levi responded that a working group on communication may be effective. This working group would coordinate regional meetings and develop a strategy for providing technical assistance to members.

Sister Kerr inquired as to how Advisory Group members would go about adding content to the NPS. Dr. Benjamin responded that Advisory Group members could make recommendations to the Council who would discuss and approve these recommendations. Dr. Levi responded that it may be more practical to talk to the Council about how to expand and build on parts of the strategy than to reopen it.

Dr. Bigby asked Dr. Levi to clarify to whom the Advisory Group is making recommendations besides the Council. Dr. Levi clarified that the Advisory Group provides recommendations to the National Prevention Council but since the Advisory Group is presidentially appointed, the Advisory Group may also have the opportunity to speak to the President and those who work for him.

Dr. Binder noted that besides engagement, how to frame the message is very important. The phrase 'public health' is sterile in contemporary society. Dr. Levi noted that Richard Binder's thinking is reflected in the NPS: the term 'public health' is not used in the document other than in the discussion of public health infrastructure.

Mr. Helms noted that there are several follow-up items that have emerged during the meeting. Advisory Group members would like to receive:

- A brief outline of the Work Plan rollout planned over the next nine months and what is already in place
- An overview of the intentions of the regional meetings
- A summary of what individual Advisory Group members have already done. This could lead to PowerPoint slides which would be the basis for talking points
- A list of any champions identified that the Advisory Group should reach out to

Dr. Murthy emphasized that messaging and engagement are separate tasks. He also suggested that when working groups are crafted, members should map metrics of success as early as possible in order to develop a plan and celebrate success. He supports the mapping of champions across sectors. He believes the Advisory Group should move beyond the role of a traditional Advisory Group and move toward becoming an action board. Dr. Mayer-Davis asked Advisory Group members to consider what activities they would take on individually and collectively. She believes that the Advisory Group should craft a focused and specific plan to accomplish as much as possible in a limited amount of time. Dr. Swider encouraged the committee to consider desired immediate, short term and long term outcomes.

Dr. Fielding reminded the Advisory Group that their role is to recommend and support the Council. He also noted that the Advisory Group must broaden the base of support for the NPS, potentially by engaging national leaders in business, healthcare and education that have a broad perspective. He agreed with Dr. Murthy's recommendation about evaluation. Dr. Levi responded that there is an opportunity to broaden the base of people engaged in this effort. He pointed out that there are vacancies and opportunities on the Advisory Group but it is important to consider whether to turn the Advisory Group into a platform for nontraditional supporters. The temporary working group will address this potential recommendation and others in their recommendation memo. It is likely that this draft recommendation memo will have to be pared down into two or three key action items.

Dr. Johansson inquired as to whether it would be possible to have a central repository for different PowerPoints and media released.

Dr. Levi noted that there are currently several efforts underway to broaden the base of the Advisory Group, and that there are some things that need to be said immediately. He noted that there was no dissent about going on the record around protecting the Prevention and Public Health Fund and continuing the Community Transformation Grants, but emphasized that a draft communication strategy would likely be longer than what can be realistically done at this time. Dr. Fielding instructed the Advisory Group to voice its support for grant programs in terms of the intended outcomes of the program and not what particular grant programs are called.

Sister Kerr inquired as to the nature of the advisory role of the Advisory Group. Specifically, she wondered how she could bring a specific health concern to the attention of the Council. She also noted that the Health Impact Assessment is a terrific integrated form of healthcare. Dr. Benjamin answered that the NPS utilizes evidence-based approaches so members could recommend increasing funding to find out more about a specific health concern.

Mr. Helms noted that this is the first time so many Federal agencies have come together. He noted that he is impressed by the Surgeon General's efforts and the Council's efforts. He would like to reiterate to the Council that the Advisory Group is impressed by their work up to this point and has a sense of urgency to continue. Dr. Benjamin and Dr. Levi agreed that passing this message along to the Council would be beneficial and would empower the Council to continue to move forward.

Dr. Levi noted that he was pleased that the majority of stakeholders that presented at the meeting were not from the Department of Health and Human Services. That is an important indication of the future of the NPS. Dr. Mayer-Davis emphasized the importance of showcasing interaction across agencies and accelerating opportunities to work collaboratively within agencies. Dr. Binder would like to see the agendas and participants of regional meetings. He inquired as to whether Advisory Group members would be welcome to attend regional meetings. Dr. Levi answered that Advisory Group members are welcome to attend these regional meetings.

As far as community engagement, Ms. Brown noticed that there were considerably fewer members of the public in attendance at this month's meeting. She attributed the lack of public representation to the last-minute meeting venue decision. In order to increase public participation, she wondered if it was possible to webcast the meeting. Dr. Levi suggested that this recommendation be included in the communications plan. He remarked that it is difficult for members of the public to choose when to engage in a 1.5 day meeting and noted that holding the meeting in DC increases the participation of interest groups but not those in the field.

He suggested that the Advisory Group consider how to structure future meetings to facilitate a webcast. Potentially the one hour Council update on implementation could become a tool for wider dissemination. Dr. Bigby echoed this sentiment, suggesting that a review of the Advisory Group's status and previous deliberations at the beginning of meetings would make it possible for the public to understand relationships between the Advisory Council and the NPS.

XIII. NEXT STEPS FOR ADVISORY GROUP; CONSIDERATION OF CONTINUATION/NEW WORKING GROUPS 12:30 P.M. – 1:00 P.M.

Dr. Levi asked for volunteers for the temporary working group responsible for drafting recommendations. Dr. Fielding, Dr. Swider, Dr. Mayer-Davis, Dr. Bigby and Mr. Helms volunteered for this group.

Ms. Brown noted that some Advisory Group members that are interested in the communications process are not currently part of the engagement working group. Dr. Levi decided to re-form the engagement working group to be the engagement/communications working group. Ms. Brown, Mr. Helms, Dr. Johannson, Dr. Mayer-Davis, Dr. Swider decided to stay on this working group. Dr. Binder and Dr. Murthy joined this working group. Meeting times will be scheduled around working group members who volunteered for the group.

The Prevention and ACA working groups will be temporarily suspended. The next working group will be decided on the next Advisory Group conference call. Dr. Levi clarified that the recommendations drafting call will take place within two weeks and suggested the group reconvene by phone in early November. He will try to arrange that date within a week in order to give sufficient public notice. Dr. Fielding suggested that there needs to be a system to organize recommendations. Dr. Levi will send a draft framework table that the Advisory Group can populate via email. This populated table could be basis for the drafting group's first discussion.

Mr. Helms clarified that the Advisory Group plans to draft a statement to the National Prevention Council to praise its work.

Dr. Fielding suggested that recommendations should consist of items that can be done internally within each of the participating agencies, items that can be done externally which focus on communications, items that can be accomplished on an individual level, mechanisms for sharing the success stories, mechanisms for developing a systematic way of collecting information about what prevention activities are occurring and how to provide incentives to look more broadly at prevention issues.

Dr. Swider suggested that the Advisory Group consider follow up steps related to grassroots level prevention. The Advisory Group's discussion touched on leadership, but grassroots level prevention can be the most effective by making prevention more accessible. Getting people on the ground to discuss prevention generates enthusiasms that last beyond agency interests.

Dr. Fielding suggested that communication efforts should answer the questions of the reasons behind the National Prevention Strategy, not just the Strategy itself. He also suggested that putting together examples of economic data would be helpful in this era of attention to cost.

Dr. Swider suggested that communication be simple and depoliticized. She provided the example of gaining more support for prevention efforts at a parent teacher meeting if she discussed the need for a new

playground or traffic calming circles rather than discussing prevention efforts in terms of the ACA. Dr. Fielding concurred about the importance of presenting data in a non-partisan perspective.

Ms. Brown encouraged the Advisory Group against "running from the Affordable Care Act because it's political." Dr. Bigby agreed with Ms. Brown and noted that coverage will make a tremendous difference and is the foundation of the successes that we want to see in improving health information. Dr. Levi also agreed, noting that the Advisory Group grew out of the Affordable Care Act. He noted that coverage is a form of prevention and that Medicaid expansion could be one of the most important changes to happen under the Affordable Care Act. The Affordable Care act also recognizes that health is not just dependent on health care but what happens outside the clinic. As people are trying to dismantle the act they are realizing that each piece of the health care equation is critical.

Dr. Swider reminded the Advisory Group about the importance of tailoring its communications message. Consumers will not likely be interested in the essential health benefits but instead will likely support the pieces that are most relevant to their lives. It is important to target people based on their interests. Dr. Levi recommended that the workgroup review messaging research and suggested that it may be necessary to step back or change courses to effectively communicate messages.

Concluding items

Dr. Levi asked Advisory Group members for any last thoughts before the meeting adjourned. Lesley Russell (from audience) noted that she had received an email from Mr. Wilson who clarified that data from early 2011 indicates that 1 million young people have been given insurance coverage as a result of being able to stay on their parents' insurance plans. The number now may be even higher.

Dr. Graffunder reminded the Advisory Group to submit all paperwork to Sharon Robinson for vouchers. She thanked Sharon for her work to organize this meeting. She introduced Judy Kuo who will assist with the logistics of working groups moving forward.