

CDC Advisory Committee To the Director Meeting October 30, 2008 Executive Summary

Includes

Agenda

List of Participants



Release Date: February 2008



Executive Summary

Julie Louise Gerberding, MD, MPH, Director, Centers for Disease Control and Prevention, convened CDC's Advisory Committee to the Director in public session on October 30, 2008, for the purpose of gaining guidance and direction on (1) CDC's budget challenges for FY 2009 and beyond, (2) CDC's role in the new global health environment, (3) Alliance for the Healthiest Nation, (4) CDC's efforts for Healthiest Nation, and (5) reports from the Ethics and National Biosurveillance Advisory Subcommittees. Eduardo J. Sanchez, MD, MPH, Chair, Advisory Committee to the Director, led the meeting and 14 of its 18 members attended.

Chair's Introductory Remarks

Dr. Sanchez welcomed the Advisory Committee to the Director members and its guests, the CDC Executive Leadership board, chairs of other advisory committees and boards of scientific counselors, other staff, and the public. He updated the committee on his attendance at a meeting on October 29 of the chairs of CDC's advisory committees and boards of scientific counselors and their designated federal officials. He updated the committee on the ceremony he attended on the evening of October 29 that recognized the CDC's Senior Management Officials who had assisted states and state health officials during hurricanes since 2004.

Director's Remarks to Create Context for the Day's Topics

Julie Louise Gerberding, MD, MPH, CDC Director, then set the context for the day's primary topics of CDC's budget challenges and role in global health, by commenting on photos collected since July 2008 during her travels as CDC Director. She showed photos of the Arctic Circle taken during her fact finding trip with a National Geographic team to discuss climate change. Photos of parts of Africa related to the new authorization of PEPFAR and the new roles it authorizes for CDC of health systems development, research, monitoring, and evaluation and to wet markets in Africa and the continuing concerns about the mutations of influenza virus and opportunities for its spread. Photos of trips to South America supported her discussion on the spread of dengue; on a new road between Brazil and Lima, Peru (disease follows roads); and also efforts by Central American countries to develop capacity to deal with potential pandemic influenza. Dr. Gerberding also discussed hurricanes Gustav and Ike and how they revealed challenges by identifying new vulnerable populations of persons weighing over 450 lbs and were responsible for unfunded mandates on CDC. She presented photos of the CDC China facilities in China and described this relationship as truly reciprocal. She showed no smoking signage in San Francisco to emphasize the progress made in California on no smoking and smoking cessation, and photos of her medical team to emphasize the international nature of the workforce. Dr. Gerberding closed with photos of the CDC Healthiest Nation exhibit at the American Public Health Association meeting in October and CDC's recruitment booths there to emphasize CDC's need to recruit the best and the brightest and our challenges in being competitive in the open market in attracting, retaining, promoting, and developing this talent—to meet CDC's national and international mission.

CDC Budget Challenges for Fiscal Year 2009 and Beyond (Part 1)

William P. (Bill) Nichols, Director, CDC Financial Management Office, described four budget challenges: (1) limited flexibility, emphasizing that most of CDC's \$11.2 billion (FY 2008) is restricted or targeted to specific areas and is provided in 200 budget lines, representing more than 100 program and 60 functional areas; (2) erosion of buying power, approximately \$1.3–\$1.6 billion since 2005, occurring from cost of living increases that must be absorbed in the current budget and Congressional rescissions; (3) Insufficient resources to support strategic initiatives such as the agency's health protection goals; (4) and no emergency funding flexibility. The Director has little flexibility in the budget to deal with an emerging issue because any redirection over \$500K requires Congressional approval. Previously there was about \$5–\$6 million in the Director's discretionary fund, but this has been zeroed out in the President's 2009 budget request. He highlighted the following needs:



- Increased flexibility in where CDC can invest.
- Expanded CDC discretionary funding capacity.
- Restored budget to account for loss of buying power.

CDC Budget Challenges for Fiscal Year 2009 and Beyond (Part 2)

Debra R. Lappin, JD, Advisory Committee Member, and Senior Vice President, B & D Consulting, LLC, followed Nichol's presentation with comparative information on the NIH budget and her insights for ways to address CDC's budgetary concerns. She described CDC's budget situation by noting that the CDC Director and agency deal with a budget that

- has extraordinary and growing complexity,
- has limited flexibility because the budget is largely fixed resources for designated areas,
- has limited strategic transagency resources to address problems that are no longer silos, but need to be addressed in collective ways because they have shared risk factors,
- does not allow flexibility for addressing emerging threats,
- has had spending/buying power erosion,
- faces new expectations for accountability.

She then offered from her experience, working on the National Institutes of Health budget challenges, possible approaches on addressing CDC's challenges:

- Several studies from the Institute of Medicine and the National Academy of Science found for NIH
 - That the Office of the Director, NIH, should have a more adequate budget to support management goals or greater discretionary authority to reprogram funding from earmarked components, i.e., in particular, if the NIH Director is given responsibility and authority to plan for trans-NIH initiatives, the Director's budget would need to be amplified to include the cost of planning.
 - They offered the following recommendations: (1) new trans-NIH planning process for initiatives that span the agency; (2) a scientific rationale for trans-NIH budgeting by the Director to be taken back to Congress for these investments; (3) requirement that agency components (institute and centers) contribute resources to this collaborative space; and (4) that a certain amount of NIH funding should go into escrow for trans-NIH initiatives, to be determined by the institutes and centers, that make sense to constituencies, advances the portfolio, and that supports appropriate staff in the Office of the Director for this process.
- Results from the release of the report: (1) received much attention and a roadmap evolved, beginning with NIH leadership exploring what trans-NIH thinking looks like; (2) roadmap was sent to Congress who responded positively and appropriated more funds for new teams, pathways, and a re-engineered clinical research enterprise, eventually resulting in \$85M to the Director for a common fund. The process was not simple, and there was push back from within NIH institutes and centers.

Budget Challenges—Comments and Discussion

- One Advisory Committee member responded that taking action quickly and within the architecture of the Advisory Committee was warranted, via a workgroup to produce within 30 days a white paper for the Director that could be passed on to current and transitioning governmental agencies. The paper should recognize that there is an insatiable demand for resources by all entities, in order to move beyond that issue. The paper should articulate (1) the importance of standby capacity (such as a police department, fire department, or hospital emergency room) as one component of this agency's work; (2) the paradox in today's budget of carrying out work within a back to basics framework when the fundamental nature of public health is changing because the nature of society and disease is changing; (3) the agency's work



around vigilance which includes national security and also looks at emerging diseases or the health of a more global population; and (4) the need for the equivalent of a common fund or discretionary movement, up and down, of funding that clearly recognizes the daily core work of CDC but also the need at any point to make shifts. Another issue is the introduction of new programs and the dropping of existing programs based on personal preferences that occur during turnover of governmental leaders. Another point to address is how programs actually produce change, and that the issues CDC deals with do not fit into a simple annual return on investment, but require long-term investments and are affected by leadership, clarity of purpose, and the budget structure.

- One of the chairs of another advisory committee commented that during resource contraction, one of the responses is to retreat into silos and another is to become more efficient, but that becoming more efficient sometimes produces the paradoxical situation of having money cut out of the budget. He asked if the committee might address this illogical consequence. His second comment addressed the push at NIH for funding for translational research which ultimately, he observed, created new mandates for CDC and changes in cost and cost allocation. He pointed out the importance of transagency discussions in this regard, not just out of courtesy, but because it is the right thing to do.
- A chair of one of the boards of scientific counselors noted that various agencies have had to deal with budget challenges and that there are lessons to be learned. One approach he noted is to prioritize, and to make cuts; for CDC states and pulling back from other countries to focus on federal responsibilities for US citizens are two difficult areas of consideration. He also noted that the constraint of management by budget lines occurs sometimes because of erosion of trust. Therefore, communicating with Congress, as has NIH, more about returns on investments is important. Another approach to Congress is to provide hard analytical data on the consequences of reduced budgets.
- Dr. Gerberding summarized that basically in budget situations, there are two choices—get more resources or spend less money, and they are not mutually exclusive opportunities. Under get more resources, one can get more appropriations, or have flexibility for core resources, or use the agency’s leverage for money from other agencies, partners, or sectors. Under spend less money; one can focus on things that are absolutely essential to CDC’s critical mission. Another element of the spend less category, is to really innovate, and she asked for thoughts on this. Dr. Gerberding also pointed out the Goal Action Plans which are already a big step by CDC to define cross-agency priorities. However, there are many priority recommendations. One area of assistance from the Advisory Committee would be to help CDC with a process to prioritize the recommendations and an understanding of how to address these priorities over a time frame that is realistic and long enough to be useful and short enough to be credible. She noted, however, the lack of resources even to get some of these efforts started.
- A member of the Advisory Committee thanked Dr. Gerberding for the clear summary of options—raising additional revenue, getting increased appropriations, or reducing expenses. He then focused on his perception that not only has there been an erosion of buying power, but also an erosion of latitude and discretion, and because there is external advocacy driving more and more line item allocation, the Director fundamentally has no ability to make choices. Thus this is the first place, a workgroup should offer help.
- Dr. Gerberding responded that all of these do account for the constrained flexibility of the agency, and in some cases, issues of trust. She also noted that the agency has achieved three of four awards for being a high performing organization, and following this efficiency, this budget line item was cut.
- Another Advisory Committee member focused on innovation, pointing out that innovation is not something that can be turned on or off, but that requires a longstanding culture change and development of capacity over time. One of the pathways to innovation might be to look within CDC’s budget lines to create incentive and reward structures that will motivate private sector partners to produce, either more efficiently or more effectively than what is currently produced by the agency.
- Dr. Gerberding agreed and noted CDC has some private, public partnerships that are remarkable, but that again, there are few resources to prime the pump for this effort.



- Another Advisory Committee member noted that due to world economic conditions, there will need to be innovation everywhere. He suggested one thing to do is to look at other agencies, and he noted that in government, one area that has shrunk and gotten more efficient is the Army, based on moving to the world of information technology. CDC should think about best practices, cost benefit analysis, and about protecting the interests of everyone it serves rather than its agency interests.
- Another member pointed out two powerful forces in a private sector, high-performing organization:
 - Serving the customer—How do we delight them?
 - Getting more productivity—How do we do that better?

He also noted that in corporations, when things are tough, the best and brightest come up with ideas to completely change the game in order to do more with less while delighting customers. He noted it is a big “ask” to get more latitude and more money at the same time and posed the question, in this environment, how much of the \$1.6B erosion in CDC’s budget could be offset if CDC had the latitude to make choices across budget areas to serve your customers with brilliance? That could be a powerful public play, i.e., if you give this agency more latitude, we will have a more productive structure and culture.

- Dr. Gerberding responded that the agency needs more information and resources to make the business case around the tradeoffs between choices.
- The member then remarked that the agency needs to act in some visible, aggressive way to provoke and get a reaction, to make some bold provocative offer, such as asking for some funds to pull the agency together to become the model agency in terms of the totality of the productivity assessment.

Budget Challenges—Advisory Committee Action

In response to the presentations and discussion, the Advisory Committee acted as follows:

One member framed a motion, “The motion is for the Advisory Council [Committee] to appoint an ad hoc group to provide recommendations to the Director via the entire committee and require either an e-mail discussion or a web based/teleconference to get some buy in around principles for change, in terms of the budget and the budget structure and process for the agency, and have that done within 30 days.” This was amended to state “within FACA rules.” The motion was seconded and approved.

CDC’s Role in the New Global Health Environment (Part 1)

Stephen Blount, MD, Director, Coordinating Office for Global Health, stated that globalization is a critical issue for CDC and that CDC’s global portfolio has grown dramatically. He noted that

- CDC has had a dramatic increase in international funding over the last six years, most of it for President Emergency Plan for AIDS Relief (PEPFAR), but also for other major efforts including the global immunization program focusing on polio eradication and measles, the President’s Malaria Initiative, and for international influenza activities.
- CDC has 224 staff (US government employees) assigned to 54 countries and 1,200 locally employed staff.
- CDC’s overarching global goal is “Healthy People in a Healthy World” covering global health protection, promotion, and health diplomacy.
- CDC’s global core competencies:
 - Surveillance and strategic information systems
 - Translation, implementation, and operational research
 - Strengthening in-country health systems and laboratories
 - Unique workforce skills, not only technically but diplomatically to understand and work with other countries, sometimes allowing us to work on issues other US agencies cannot access.



He cited these major challenges:

- Workforce—keeping up with the demand for well-qualified, well-trained, experienced staff. One effort to assist in this is to build in country capacity, i.e., the field epidemiology and laboratory training program, based on the CDC's Epidemic Intelligence Service. The Management Development Training Program is a complementary program.
- High expectations to respond to a variety of national disasters, terrorist attacks, etc. abroad, and that most are unfunded.
- Meeting the opportunities offered by working with partners—nongovernmental organizations, US corporations, foundations, ministries of health, and other US government agencies—State Department, Defense Department, and USAID.
- Outmoded business systems that do not facilitate working across the world.
- Moving people, money, information, and specimens around the world.
- Communicating about CDC's international work.
- Limited expertise and knowledge in some areas necessary to work effectively for health—global financial issues, foreign policy, language skills, etc.

CDC's Role in the New Global Health Environment (Part 2)

Guest speaker, Carol J. Lancaster, PhD, Professor of Politics in the School of Foreign Policy and in the Department of Government, George Washington University, and Director of its Montara Center for International Studies and its new initiative on international development, began her remarks by discussing the broad context of foreign assistance.

- Her view of foreign assistance is the transfer of public resources from our government or other governments to recipient governments, international organizations, private entities, nongovernmental organizations for the broadly defined purpose of development. This is also the official definition of foreign aid that is used by the Organization for Economic Cooperation and Development (OECD). This is not export promotion, not cultural exchange, not military assistance, but something different.
- The United States provides about \$25 billion a year in foreign aid, with the world—the OECD countries and maybe a few of the oil producing countries and others—providing collectively about \$100B a year.
- The three major purposes are disaster relief, diplomatic purposes or direct support of US foreign policy (about 50 percent), and development or to promote growth in poor countries and to reduce poverty.
- Development means many things to many people, such as focusing on public goods, one of which is promoting global health and fighting infectious disease, and another is democracy promotion.
- Development is the means to an end for many because it expresses our values; and for others it is a means to an end for national security, i.e., a way of reducing problems such as poverty and deprivation that feed terrorism, and certainly since 9/11.
- The main topic of discussion has been about the organizational structure of foreign aid. There are probably 50 units of the U.S. government that provide foreign aid.
- The programs are as follows:
 - The largest is PEPFAR, located in the Department of State who then distributes the funds to CDC and others for the program's implementation.
 - Development assistance monies, USAID.
 - Other monies to the Department of State who decides where and how much goes to whom but implemented by USAID.
 - Food aid, Department of Agriculture but implemented by USAID.
 - The Millennium Challenge Corporation, the new aid agency, based on a different business model for assistance that emphasizes the responsibility of the recipient countries and the recipient governments, to decide how the aid is used and used effectively.



- Numerous small aid programs; nearly every governmental agency—Department of Health and Human Services, Energy, Treasury—have programs.
- Increasingly the Department of Defense is involved with foreign aid.
- An important question is how much of a military face should be on foreign aid for development? A military face is likely appropriate where there is military action, but what about in places where we are not militarily engaged. Diplomacy, development, and defense have been referred to as the 3Ds. Part of the discussions is how to achieve this through organizational structure?
- There have been basically two or three proposals for reform.
 - The main one has been to create a new Cabinet level development agency.
 - Option two is to put together the three major bilateral aid programs, PEPFAR, the USAID program and other aid programs in the State Department, and the Millennium Challenge Corporation.

Another debate that does relate to CDC's activities is about what we should do with our development assistance abroad. Should we promote development as a panoply of changes in country, education, agriculture, health small business, health, etc. or should we focus on global public goods, such as the international transmission of disease. This question may have already been answered without the debate because close to half of the aid money is going into global health and PEPFAR (\$10B per year) is the largest aid program, and in the 14–18 target countries, it is all the aid money we provide.

Dr. Gerberding asked if Dr. Lancaster had any specific advice for CDC.

Dr. Lancaster offered the following (1) that CDC should consider that the availability of money that is not aligned with CDC's mission could eventually cause CDC to lose its mission. (2) She said she would like to see CDC more engaged in policy discussions, not just for global health, and suggested that if there is a CDC policy office that would allow CDC to participate in these discussions, noting that many of these discussions are in Washington.

Comments and Discussion

Dr. Sanchez asked what role the Advisory Committee might play.

One member of the Advisory Committee suggested the possibility of another type of advisory board or committee that might include people like the Madeline Albrights of the world.

An Advisory Committee member suggested that because there is currently a vacuum in the news, he thought it important for CDC to use the media relative to its brand, providing information about the global initiative, and that would help bolster the position of CDC to be at the table.

Several members offered to provide suggestions to the Director regarding CDC branding in the global context in the near future.

Alliance for the Healthiest Nation

James Nicholson Baird, Jr., MD, Advisory Committee member, and Executive Director of the Alliance for the Healthiest Nation, began his remarks by showing a video, produced by Joey Reiman, CEO of BrightHouse that described Healthiest Nation. He updated the committee on progress since the launch of the Alliance in July 2008 at the Leaders to Leaders Conference:

- An acceleration in alliance membership to 510 members, including Advisory Committee members' organizations—Target, Wal-Mart, Humana, B & D Consulting.
- A contract with BrightHouse redesign of the Web site and viral marketing issues.
- Use of the logo “In support of Healthiest Nation” on all CDC materials, reports, power point presentations The alliance with the help of BrightHouse has established five guiding principles: Help the



grass roots grow, engage in the conversation, coalesce the voices, make it easy to make the right choices, and measure what matters.

- The alliance is also continuing to measure what resonates with people on the Healthiest Nation. The alliance is working with Microsoft and Target on a LEED certification concept.
- The alliance is working with Humana and also the Healthiest Cities, as well as with the Institute for Healthcare Improvement and its Triple AIM program.
- The alliance is exploring sustainable funding for the alliance, securing its name and trademark and applying for 501c 3 status, meeting in December to plan and form its governance structure, and is seeking to engage an interim board chair.

CDC's Efforts in Healthiest Nation

L. Casey Chosewood, MD, Chair, of CDC's Healthiest Nation Coordinating Council, discussed Healthiest Nation as a grassroots movement, the means and ways to achieve a Healthiest Nation, and CDC's role in it.

- As a grassroots movement, all sectors of society need to be engaged from private individuals, corporations, schools, local boards of health, state and federal partners, faith based groups, civic and social organizations.
- CDC can engage organizations in a strong policy movement, Health in All Policies, at the local, state, and federal levels, and to make health the default and the easier choice through the built environment.
- CDC is developing a communication and marketing plan to include social networking and some high visibility target interventions with appropriate measurements
- CDC is working for improvements in health equity.
- CDC is supporting the development and use of the Health Protection Game.
- CDC is helping develop appropriate measures of wellness—indices for measuring community health, individual health, and corporate health, including working with Wisconsin to expand and use their community health measurement model.
- Lastly, we are using our research agenda and our Goal Action Plans to move Healthiest Nation forward.

Healthiest Nation—Comments and Discussion

One member of the Advisory Committee complimented

- The importance of the digital platform and all its tools for creating a culture of health, its capacity for fund raising, by allowing many small donations to turn into large numbers, and using that as a measure of how the Healthiest Nation message is getting out.

Chloe Tonney, Vice President for Advancement, CDC Foundation, commented on how the Foundation is involved in support of the alliance.

- First, the Foundation supported a meeting in September of business leaders and some members of the Advisory Committee, to talk about how to engage corporate America and business leadership.
- Second, the Foundation's Board of Directors has made a grant to the alliance to support several activities including the upcoming meeting in December on strategy and governance.
- Third, the board has agreed to support a consultant on grass roots efforts, of the alliance's choosing.
- Fourth, the Foundation is working to offer office space to the alliance in Atlanta to help leverage Foundation relationships with the alliance.

Dr. Hooeyman and Dr. Popovic announced that the Ethics Subcommittee would be exploring the ethical importance of Healthiest Nation as an essential approach to achieving health equity.



Several members discussed the opportunity of using Healthiest Nation in childhood, adolescent, undergraduate, and graduate education to increase the interest in science and health.

Ethics Subcommittee

Ms. Vivian Berryhill, Advisory Committee Member and Member of its Ethics Subcommittee introduced the report, “Ethical Guidance for Public Health Emergency Preparedness and Response: Highlighting Ethics and Values in a Vital Public Health Service” and Thomas Hooeyman, PhD, Chair of the Ethics Subcommittee, to describe its history and also its general content.

Dr. Sanchez called for a motion that “One acknowledges the excellent work that’s been done, and second accepts the report with its framework and recommendations to be used under the guidance of the CDC Director.” The motion was seconded, voted on, and unanimously accepted.

National Biosurveillance Advisory Subcommittee

Lawrence Brilliant, MD, MPH, Chair of the National Biosurveillance Advisory Subcommittee, and Executive Director of Google.org, via Envision from Google headquarters in California, presented an update on the progress of the subcommittee, established May 1, 2008, by the Advisory Committee.

- The purpose of the subcommittee is to review and look at national biosurveillance strategy and to do it annually. Some of the important things being looked for are finding innovations in biosurveillance capability; understanding the scope of biosurveillance; and seeing what is or is not working, requiring some strategic emphasis on outcome or program evaluation.
- The subcommittee has 32 members, is divided into eight taskforces, and each taskforce chair or champion of a taskforce then sits on a Steering Committee.
- The subcommittee had its initial meeting in August 2008 in San Francisco.
- The goal for each taskforce, having done an industry mapping, having identified the gaps or the most important priority areas that they have the deepest concern about, is to develop (from their collective experience, the consultants they talk to, and whatever commission research has been done) their top three priority areas and develop them into a suggested plan of action by December 15. Then the chairs of all the taskforces will meet as the Steering Committee. It is hoped that there will be three priorities per taskforce—for a total of 24 priorities. In January and February, the Steering Committee will choose the most important five or six priorities bring them forward as primary recommendations. The other recommendations will be subordinate recommendations that will follow in subsequent years. The five or six selected priorities will be forwarded to the Advisory Committee no later than February/March.

Health Disparities Subcommittee

The Committee unanimously approved the appointment of two members, Dr. John Seffrin and Dr. Nisha Botchwey, to the Health Disparities Subcommittee.

Public Comment Periods

Two public comment periods were offered, one in the morning and one in the afternoon. Only one person spoke and he addressed Morgellons disease. He requested that the disease be studied, that a Dear Doctor letter be written, and a database started.

Dr. Sanchez replied that CDC has a website with information about Morgellons disease, and that we would take a next step that would be appropriate, and although not a Dear Doctor letter to every doctor in America which would be challenging, to send a Dear State Medical Association letter about the disease, based on the science and the medical information available, and ask them to share with their association membership.



Influenza Immunizations

At breaks and lunch, the Advisory Committee members, as specially designated federal employees, were offered the opportunity to receive influenza immunization, and some accepted.

Closing Remarks

The meeting ended with the acclamation from the Committee for the leadership provided by the CDC Director, Julie Louise Gerberding, MD, MPH.

Overall Meeting Accomplishments

- The CDC Director presented context for the meeting's topics.
- Committee members were informed about budget challenges facing CDC, openly discussed these issues, and established a workgroup to provide guidance within 30 days to the Director.
- Committee members were informed about some of CDC's global health work and issues impacting this work and engaged in discussion of these issues. Several members offered to provide suggestions to the Director regarding CDC branding in the global context.
- Committee members were updated on progress of the Alliance for the Healthiest Nation and CDC's actions for Healthiest Nation and engaged in discussion of these actions and offered guidance.
- The committee unanimously accepted the report, "Ethical Guidance for Public Health Emergency Preparedness and Response: Highlighting Ethics and Values in a Vital Public Health Service" from the Ethics Subcommittee.
- The work and progress of the recently established National Biosurveillance Advisory Subcommittee was presented. This included a list of its members, its infrastructure of taskforces and steering committee, its charge, meetings to date, operational plan, and timelines.
- The committee unanimously approved the appointment of two members, Dr. John Seffrin and Dr. Nisha Botchwey, to the Health Disparities Subcommittee.
- Public comment periods were provided and the committee received one public comment.
- Members, as specially appointed federal employees, were offered influenza immunizations and some accepted and were immunized.
- The committee recognized and applauded the leadership provided by Julie Louise Gerberding, MD, MPH, Director, Centers for Disease Control and Prevention.

The next Advisory Committee to the Director meeting is planned for April 30, 2009.



Appendix A

May 1, 2008 Meeting Agenda

Advisory Committee to the Director

May 1

8:00–8:30 am	Welcome and Introductions Dr. Eduardo Sanchez, Chair, Advisory Committee to the Director Advisory Committee to the Director Swearing-In by Mr. Galen Carver and USPHS Honor Cadre*
8:30–9:45 am	Director's Charge, Priorities, and Discussion Dr. Julie Gerberding
9:45–10:00 am	Public Comments
10:00–10:15 am	Break
10:15–10:45 am	Background and Progress: <i>A Healthiest Nation</i> Through Health System Transformation
10:45 am–12:15 pm	Input, Discussion, and Recommendations on CDC's role in <i>Healthiest Nation Alliance</i>
12:15–1:00 pm	Lunch
1:00–2:30 pm	Continued—Input, Discussion, and Recommendations on CDC's Role in <i>Healthiest National Alliance</i>
2:30–2:45 pm	Public Comments
2:45–3:45 pm	Advisory Committee to the Director Subcommittees and Other Group Work—Recommendations and Decisions
3:45–4:00 pm	Summary and Concluding Remarks Dr. Sanchez

*Galen P. Carver, MS, PE, Director, Atlanta Human Resources Center
U.S. Department of Health and Human Services
Members of the USPHS Honor Cadre



Appendix B Participants

Advisory Committee to the Director

Chair: Eduardo J. Sanchez, MD, MPH, Vice President and Chief Medical Officer, Blue Cross and Blue Shield of Texas. Previously, Institute for Health Policy, Professor, Division of Management, Policy and Community Health, The University of Texas Health Science Center at Houston School of Public Health

James Nicholson Baird, Jr., MD, Executive Director, Alliance for the Healthiest Nation
President, Stillwater Solutions, LLC

Vivian Berryhill, President and Founder, National Coalition of Pastors' Spouses

Nisha D. Botchwey, PhD, Assistant Professor, Urban and Environmental Planning and Public Health, School of Architecture, University of Virginia

Sanford R. Climan, MBA, MS, President, Entertainment Media Ventures, Inc., and Executive Producer, U23D

Mark A. Collar, Partner, Triathlon Medical Ventures, and former President, Global Pharmaceuticals and Personal Health, The Procter & Gamble Company, Inc.

Suzanne F. Delbanco, PhD, President, Health Care Division, Arrowsight, Inc.
Former CEO of the Leapfrog Group

Linda M. Dillman, Executive Vice President, Benefits and Risk Management, Wal-Mart Stores, Inc.

Mary Kelly, formerly Vice President, General Merchandise Manager, Healthcare, Target Stores, Inc

Debra R. Lappin, JD, Senior Vice President, B&D Consulting, LLC

Jonathan T. Lord, MD, Senior Vice President and Chief Innovation Officer, Humana, Inc.

Kenneth D. Mandl, MD, MPH, Associate Professor, Harvard Medical School, and Director, Intelligent Health Laboratory, Children's Hospital Informatics Program, Children's Hospital Boston

Thomas C. Nelson, PhD, Chief Operating Officer, American Association of Retired Persons

John R. Seffrin, PhD, Chief Executive Officer,
American Cancer Society

CDC Executive Leadership Board

Julie Louise Gerberding, MD, MPH, Director, Centers for Disease Control and Prevention

Stephanie B. C. Bailey, MD, MS, Chief, Office of Chief of Public Health Practice, Office of the Director

Richard E. Besser, MD, Director, Coordinating Office for Terrorism Preparedness and Emergency Response



Stephen B. Blount, MD, MPH, Director, Coordinating Office for Global Health

Mitchell L. Cohen, MD, Director, Coordinating Center for Infectious Diseases

Henry Falk, MD, MPH, Director, Coordinating Center for Environmental Health and Injury Prevention

Donna Garland, Chief, Office of Enterprise Communication, Office of the Director

Joseph M. Henderson, MPA, Acting Chief Operating Officer, Office of Chief Operating Officer, Office of the Director

Bradley A. Perkins, MD, MBA, Chief, Strategy and Innovation Officer, and Chief, Office of Strategy and Innovation, Office of the Director

Tanja Popovic, MD, PhD, F(AAM), AM(AAFS), Chief, Office of Chief Science Officer, Office of the Director

Donald E. Shriber, JD, MPH, Director, CDC Washington Office

Steven L. Solomon, MD, Director, Coordinating Center for Health Information and Service

Stephen B. Thacker, MD, MSc, Chief, Office of Workforce and Career Development, Office of the Director

Kathleen E. Toomey, MD, MPH, Director, Coordinating Center for Health Promotion

CDC Foundation

Phil Jacobs, Chair, CDC Foundation Board of Directors and Retired President, AT&T, Southeast Business Communications Services

Charles Stokes, President and CEO, CDC Foundation

Chloe Knight Tonney, Vice President for Advancement, CDC Foundation

