

Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
March 28–29, 2013
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC

Attendees:

Advisory Group Members:

Jeffrey Levi (Chair), Richard Binder, Valerie Brown, Jonathan Fielding, Patrik Johansson, Jerry Johnson, Janet Kahn, Charlotte Kerr, Jacob Lozada, Vivek Murthy, Dean Ornish, Barbara Otto, Herminia Palacio, Linda Rosenstock, John Seffrin, Ellen Semonoff (participated in Day 1), Sue Swider, Sharon Van Horn, Kimberlydawn Wisdom

Regrets: Judy Ann Bigby, Elizabeth Mayer-Davis, Ned Helms

HHS Staff:

Regina Benjamin, Corinne Graffunder

Panelists:

Norris Dickard, Department of Education	Carol Naughton, Purpose Built Communities
Ian Galloway, San Francisco Federal Reserve Bank	Suzi Ruhl, Environmental Protection Agency
Bryna Helfer, Department of Transportation	Ellen Semonoff, City of Cambridge, MA
Claude-Alix Jacob, City of Cambridge, MA	Matias Valenzuela, King County Equity and Social Justice
Sunaree Marshall, Department of Housing and Urban Development	Steven Woolf, Virginia Commonwealth University

8:30–9:15 a.m. Welcome and Introductions

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 fourth meeting of the Advisory Group.

Dr. Benjamin welcomed the group and thanked everyone for their support on the work that has been accomplished so far.

Dr. Benjamin introduced Dr. Corinne Graffunder, the Designated Federal Officer (DFO) for the Advisory Group, who took the roll call and provided an overview of logistical elements of the meeting.

Dr. Levi provided an overview of the [agenda](#).

Dr. Levi turned the meeting over to Dr. Benjamin for an update on the [National Prevention Council Action Plan](#).

9:15–9:30 a.m. Update on the National Prevention Council Action Plan

Dr. Benjamin began by stating that the vision for the NPC is to move our healthcare system from one that focuses on illness and disease to one that focuses on prevention and the goal is to increase the number of Americans that are healthy at every stage of life. Dr. Benjamin stated that each year, a status report on the NPC is presented to the President. The last report was delivered on June 2012 and includes the [National Prevention Council Action Plan](#) to make sure the NPS is a living document. The action plan highlights how the various federal departments have already been working on prevention. Examples include:

- Department of Transportation Safe Routes to School
- USDA MyPlate
- HUD with the smoke-free multi-housing unit authority
- Office of National Drug Control Policy

Dr. Benjamin continued, stating that the action plan also highlights future efforts. Each department has committed to three things: 1) increase tobacco-free environments, 2) improve access to healthy affordable foods, and 3) put a health lens on all of their activities. She added that in order to make the NPS come to life, the Office of the Surgeon General (OSG) has been working with a number of groups over the last several months. For example, the OSG:

- Recently hosted a White House invitational meeting with Dr. Benjamin and Association of State and Territorial Health Officials (ASTHO) to discuss opportunities to advance the NPS on a statewide level.
- Held a regional meeting in Detroit with community leaders, business leaders, foundations, and a range of organizations interested in the health future of Detroit.
- Participated in the Health Disparities summit held in December with leaders from four NPC departments to discuss how their departments support prevention.

Dr. Benjamin shared her appreciation for the Advisory Group and the work that they are doing and turned over the meeting to Dr. Levi.

Dr. Levi asked if there were any questions and wanted to know if there is a formal or informal way of documenting how the concepts of NPS are being embraced by states and localities. He noted that it would be important to see the degree to which the approach is being integrated and replicated.

Dr. Benjamin asked Dr. Dawn Alley, Senior Policy Advisor in the Office of the Surgeon General, to address the question. Dr. Alley stated that the OSG is working closely with CDC to reach out to local communities. She stated that CDC will be looking at opportunities to capture some of the work being done from Sonoma, California, to the University of New Hampshire. Dr. Alley noted that OSG is looking for ways to evaluate and easily document efforts. These include the number of times NPS is being downloaded, the number of times NPS is cited in state reports, etc. She mentioned that they are also looking for opportunities to create more meaningful measures and ideally an evaluation or surveys of states to see where NPS is being used in a systematic way.

Dr. Benjamin noted that ASTHO has a small grant from CDC to pull together the organizations that met at the White House and document their work. OSG is open to ideas on documentation.

Dr. Vivek Murthy asked if feedback had been received from others about the reports submitted. Dr. Alley responded that they did brief members of Senator Harkin's staff after the release of the status report and action plan last year. She noted that Senator Harkin's staff was extremely positive and that the day before, there was a briefing with Senator Lautenberg's staff around tobacco work and an ongoing effort to reach out proactively to members of Congress.

Dr. Levi stated that the group might consider for the next Annual Status report organizing a bipartisan briefing through the Senate HELP Committee and the House Committee on Energy and Commerce.

Dr. Jonathan Fielding commented that a briefing makes sense and encouraged providing examples from different parts of the country.

Dr. Levi provided an update on the Advisory Group recommendations:

- 1) One recommendation was to preserve and protect the Prevention and Public Health Fund (PPHF). Dr. Levi noted that there were attempts to repeal the PPHF along with other parts of the Affordable Care Act (ACA). All of those attempts failed. The PPHF was subject to sequester and lost \$70 million. He added that this is not an across-the-board cut to each of the items funded in the PPHF and that there is some flexibility on how the sequester is implemented. The FY 13 allocation for the PPHF has not been made. He noted that we will know soon how it has been allocated.
- 2) The second was a recommendation that the Medicaid program be more flexible and allow for reimbursements for prevention activities from non-licensed practitioners. This would help encourage states to reimburse for programs like the lifestyle programs delivered by non-licensed providers. The specific language, included in a propose rule regarding essential health benefits under Medicaid, was changed to remove the restriction. It states that if a service is recommended by a licensed provider then the state Medicaid agencies may reimburse for it. If included in the final ruling, implementation will be a challenge on multiple levels:
 - It will still be up to the states to decide to take advantage of the opportunity.
 - States will want to know what programs are evidence-based.
 - Clinicians will need to know what programs in their community are covered. They will need to be referred to quality programs.

Dr. Levi reported that there are conversations happening between CDC and CMS about next steps and it might be worth revisiting this recommendation in six months and obtaining an update from the CDC, CMS, state Medicaid directors, and others about the progress toward a final ruling.

- 3) Dr. Levi continued with the last recommendation update and the discussion around community benefit and the new IRS regulation on what could count as community benefit and if more upstream investments in prevention and health promotion could count towards community benefit. Dr. Levi stated that the Advisory Group's letter to the IRS was heard and there was a follow-up meeting. Dr. Levi reported a tremendous openness and said that the activities discussed are permissible, but it has not been communicated well to hospitals. The IRS language is not clear enough and there will be ongoing discussions.

9:30–9:45 a.m. IOM report — *U.S. Health in International Perspective: Shorter Lives, Poorer Health*

Dr. Levi introduced Dr. Steven Woolf who provided a summary of the IOM report *U.S. Health in International Perspective: Shorter Lives, Poorer Health* and noted that this presentation will be useful for framing and serving as a reminder that the United States has a long way to go in achieving health outcomes that our counterparts in other countries have already accomplished. The report includes recommendations and points to NPS as a potential vehicle for addressing some of these issues. Dr. Woolf was chair of the IOM Panel on Understanding Cross-National Health Differences among High Income Countries. The summary IOM report and Dr. Woolf's full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

9:45–10:45 a.m. Addressing the National Prevention Strategy's Strategic Direction "Elimination of Health Disparities" Through Partnerships

Dr. Levi introduced the next speakers — Ms. Ellen Semonoff, Assistant City Manager for Human Services, Cambridge, Massachusetts, and Claude-Alix Jacob, Chief Public Health Officer in Cambridge, Massachusetts — to present their work. He noted that Cambridge, Massachusetts, was one of the RWJF's Roadmaps to Health prize winners. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Dr. Levi introduced Carol Naughton from Purpose Built Communities. Ms. Naughton began her presentation about their work in the community of East Lake Meadow, Georgia. Although it was not originally designed to impact health, the project *has* had a health impact. The goal is to create a neighborhood that will be healthy and sustainable and create a platform for low-income families to break the cycle of poverty. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Dr. Levi introduced Dr. Matias Valenzuela, Manager for Equity and Social Justice in King County, Washington. Dr. Valenzuela discussed the work in King County and the framework of equity and social justice. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Dr. Levi introduced Mr. Ian Galloway, Senior Research Associate from the Federal Reserve Bank of San Francisco, to discuss two initiatives:

- Healthy Communities Initiative — Launched in 2009, this is a partnership between RWJF and Federal Reserve with the goal of turning community developers into action arms for public health.
- *Investing in What Works for America's Communities* — A collection of 28 essays from experts with the goal to encourage anti-poverty policy and practice to be more data-driven, coordinated, etc.

The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Question and Answer Session Highlights

Dr. Levi asked the panel how their work is being financed and to describe the idea of social impact bonds.

Dr. Valenzuela responded that there is not a separate budget for the equity and social justice efforts. There are two employees that are devoted to it and there is no separate equity office. It's integrated into all of the work.

Ms. Semonoff responded that funding for the projects described included direct city funding, private foundation funding, and funding from the redirection of staff work. For broader initiatives, funding comes from city and state, parent fees from those who can afford services, and redirection of funding.

Ms. Naughton responded that their work is funded through a series of public-private partnerships, for example, Hope VI and/or Choice Neighborhoods programs. On the education side, programs use charter schools that are traditionally not funded the same as public schools and additional funds (\$500/student/year) have to be raised from philanthropic sources.

Mr. Galloway provided more detail about social impact bonds, which are a form of pay-for-success financing. It has two parts, the first of which is a performance-based contract. For example, a city enters into a contract with a provider of a program to reduce childhood obesity. The contract specifies how much the nonprofit will reduce the incidence of childhood obesity, and if they are successful, they will be paid out a sum of money. The second piece is that the nonprofit provider has to raise funds upfront to pay for the cost of the program. The social impact bond is the financing mechanism. Social impact bonds started in United Kingdom and were implemented as a pilot program to reduce recidivism in Peterborough Prison.

Mr. Jerry Johnson asked if there are efforts similar to the Federal Reserve Bank of San Francisco initiatives in other communities. Mr. Galloway responded that the Healthy Communities effort has been adopted by half of the Federal Reserve regional banks and they are taking it in different directions.

Dr. Palacio asked Mr. Galloway: What are the sentinel opportunities where pay-for-success programs will have a better chance of success? Mr. Galloway responded that the goal for the issue of the journal is to deconstruct pay-for-success and reach out to those who have great knowledge and write about the topic.

Dr. Sue Swider asked Dr. Woolf about next steps around the communication of the report findings on a larger scale. Dr. Woolf responded that the funder for the panel did not have a lot of resources around communication. He mentioned that this requires a proper communication strategy to raise public awareness and through informal connections with policy leaders and other stakeholders.

Dr. Murthy asked: What are the obstacles to scaling up these programs or developing them in other communities? Is it government or is it private entities that should drive the solution? Ms. Naughton responded that the preconditions for success are important: leadership, opportunity for mixed-income housing, and opportunity to take on school reform. Funding and dollars are now very limited and there has to be a willingness for local leaders to challenge existing systems, e.g., school systems, and be disruptive.

Mr. Galloway commented that government has a huge role to play in pay-for-success, but it is a different role than they have been playing. He noted that public funding creates a silo effect with one agency

paying for housing, one paying for health, and another paying for education. The result is a hodge-podge of programs and not necessarily efficient. Pay-for-success is designed to fix that problem and allows government to be a payer for success rather than an underwriter of programs. One role for government is the ethics to pay-for-success and the consequence of introducing private sector discipline into these settings. .

Dr. Fielding asked Dr. Woolf: What are the three things that we can do now to bring the United States into the middle of the pack around mortality rates?

Dr. Woolf responded that the main message is that the solution is not more healthcare and it is important to help policymakers connect all of the dots and understand the connections between social policy and health. He stated that health-in-all policies is a far more effective approach than pouring more money into healthcare. Unfortunately, most communities don't have progressive examples as those on the panel. He stated that the message to policymakers is that even though the fiscal environment is pushing them to cut back, that could have catastrophic consequences.

Dr. Fielding asked Dr. Woolf to explain the higher life expectancy for those that reach age 75. Dr. Woolf responded that there isn't one clear answer. He stated that it may be a selection phenomenon or reflect how the U.S. cares for people at the end of life. The field has not figured it out yet.

Sister Kerr asked Dr. Woolf: Why do we think we are so healthy when, in fact, we are not? All this info is in the data, but behavior has not changed. What's the problem?

Dr. Dean Ornish commented that part of the reason may be that the most expensive treatments don't always work. He noted recent research on angioplasties and stents, showing that they may not prolong life or prevent heart attacks.

Dr. Woolf responded that it may be part of the problem and noted that there are suggestions that too much healthcare can be harmful. He stated that the panel produced a science-rich report with lots of data, but in this cynical time, facts don't necessarily change the conversation. Dr. Woolf mentioned that there is a need to move beyond just presenting data and to frame and tell the story in a more compelling way. For example, we need to communicate to parents that their children may not have as long a life. He stated that the other side is the economic argument and demonstrating that social programs are improving health, but also improving the local economy.

Dr. Wisdom asked about sustainability and if the panel is identifying community anchors to sustain their efforts. She also asked if there had been any unintended consequences of their efforts. Ms. Naughton responded that they are taking advantage of all the resources that are available in the different communities that they are working with. In East Lake, there were no anchor institutions, but in Omaha, Nebraska, there is Creighton University and their healthcare system is at the planning table.

Dr. Levi adjourned the panel and the group for lunch.

1:15–2:45 p.m. Partnerships that Address Health and Social Determinants of Health — National Prevention Council Representatives

Dr. Levi introduced the next speakers, members of the National Prevention Council, who presented on how they are addressing health and social determinates of health.

Mr. Norris Dickart, Department of Education (Dept. of Ed), began the presentation. He stated that the Dept. of Ed has a stake in prevention and a long history of being engaged in areas of prevention, violence and substance use prevention, mental health, and other areas. Dept. of Ed Secretary, Arne Duncan understands the connection between health, wellness, and academic success. The Department is focused on students' college readiness and understands that safe and healthy students are better students. Mr. Dickart described Dept. of Ed initiatives including the Promise Neighborhoods program, Successful, Safe and Healthy Students, and the Green Ribbon Schools Initiative.

Ms. Suzi Ruhl from the Environmental Protection Agency continued the presentation. She noted that the theme of her presentation is connecting the dots and is designed to accomplish three things: 1) help connect the dots of health and equity particularly around environmental justice, 2) extend an invitation to join with venues that are natural allies, and 3) focus on possible next steps. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Sunaree Marshall of the Office of Sustainable Housing and Communities, HUD, presented on the department's strategy, which includes two goals: 1) utilizing housing as a platform to improve quality of life, and 2) promoting sustainable and inclusive communities. Ms. Marshall described HUD programs including the Sustainable Communities Initiative, Choice Neighborhoods Initiative, and the Healthy Communities Transformation Initiative. She also reviewed how HUD's contribution to the National Prevention Strategy represents many different areas — from lead hazard control to asthma reduction to pest control management. It also includes work with special population issues such as low-income populations, people with HIV/AIDS, and homeless populations. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Dr. Bryna Helfer, Director of Public Engagement for the Department of Transportation (DOT), began her presentation:

- **Problems and challenges:** With injury prevention, traffic fatalities are declining, but fatalities/injuries are rising in bike and pedestrian incidents. As we improve the built environment, safety needs to be addressed. Access to key community institutions is critical. For example, Medicaid spends \$700M in non-emergency transportation services. One challenge is agencies and organizations don't talk together. The injury prevention community, planners, disability community, and schools, etc. work on their own even though we all have the same goal to enhance healthy communities. How do we accomplish it?
- **Health and transportation tool:** DOT is working with the CDC and the American Public Health Association on developing a health and transportation index tool to help planners integrate health indicators, but we speak a different language. It is important to think about it together and get together in different communities. Regional roundtables are one strategy. The President has asked every senior official to do roundtables and hear from local stakeholders. DOT has completed

3,000 roundtables around targeted issues. We need to make sure the health community is at these roundtables to break down barriers.

Question and Answer Session Highlights

Dr. Levi thanked the presenters and offered that one place to start might be with the Community Transformation Grant awardees that are already doing this type of work on the ground.

Discussion ensued about different and new structures around ACA that provide opportunities to create more synergies among federal agencies. For example, CMS is doing demonstration projects around asthma and healthy homes. In Chicago, Illinois, there is an effort around providing stable housing as a way to manage healthcare costs. Health dollars can be paying for some of these things because there is an immediate return.

Ms. Ruhl mentioned that one of the strengths of the partnership around EJ Communities is the recognition that three agencies needed to align their funding. They looked to see how funding streams could be integrated.

Ms. Marshall mentioned that the process of collaborating across federal agencies is difficult and it has taken 3 years to be able to put language in each other's grants and acknowledge the synergy. This is a story that is not often told, but perhaps this is the real story. She stated that when DOT and HUD had money for grants, the agencies worked together, deciding to hold grant competitions at the same time and allow communities to determine how they might use two funding streams. It is difficult to move beyond the bureaucracy and important to find the right person to change it.

Ms. Ruhl noted that the partnership around EJ Communities was initially created with HUD and DOT. The group initially spent time focusing on understanding each partner's language and finding common definitions. The group met for 6 months and then developed special topics.

Dr. Fielding wanted to know what is happening with the health impact assessments. It is in the law but it has not been observed. Ms. Ruhl responded that along with health impact assessments, there are the environmental impact assessments. As an example of the progress on health impact assessments, the Office of Environmental Justice is working to develop a memorandum of understanding with the Pew Center.

Dr. Fielding asked how difficult is it to talk about health, as opposed to using words like quality of life. He asked if health sometimes gets in the way when talking to colleagues.

Ms. Marshall responded that it depends on who you work with or for. With urban planners or economic development people, quality of life terminology is sometimes used. In the community, everyone talks about health and asks what HUD is doing around health.

Ms. Ruhl stated that we need to include health because of the economic benefits. Many people think this is just an HHS responsibility. However, people in the community want to hear about health. It is important to think about the audience when using different terminology.

Sister Kerr asked if technology (webinars, email) were used to build relationships. Ms. Ruhl responded that it was all about getting in a room and talking face-to-face.

3–3:45 p.m. Integrative Health Working Group — Janet Kahn PowerPoint Presentation

Dr. Levi introduced this portion of the agenda, featuring reports from the working groups to bring everyone up to date and also to prepare for the following day's discussion around the work plan. Dr. Kahn of the Integrative Health Working Group started off the conversation. The full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Dr. Kahn stated that there are four phases to her presentation: 1) what the group has accomplished over four meetings, 2) ACA support for integrative health, 3) a summary of what the working group would like the Advisory Group to focus on, and 4) a summary of Dr. Ornish's essay, *The Power of Lifestyle Changes*, which he would discuss in greater depth. Dr. Kahn's full presentation can be found on the Prevention Advisory Group Meetings [webpage](#).

Accomplishments of the Integrative Health Workgroup: One purpose of the working group is to make visible the integrative health aspect of the Advisory Group. The working group held four phone calls and discussed definitions of integrative healthcare, promotion, prevention, and other terms. Initial steps were to look at where within the ACA support for integrative health rests and what in particular are the barriers to having greater access to integrative health. The working group focused on Section 2706 of the law that makes it illegal for an insurer or insurance plan to discriminate against a healthcare provider as long as that provider is operating within that state's licensed/certified scope of practice.

Support for integrative health in the ACA: One element of the law that addresses integrative healthcare was the creation of the National Healthcare Workforce Commission to conduct evaluation of training activities to determine if healthcare needs would be met by the current workforce. Within the section of law, it offered a new definition of the healthcare workforce which included licensed complementary and alternative medicine providers and integrative health practitioners. The barrier is that there is no appropriation written in for the National Healthcare Workforce Commission. A team of commissioners were appointed but they do not have funding. Consider requesting that DOL or Bureau of Labor Statistics to include licensed complementary and alternative medicine professions in their health occupations reports. Section 3502 of the law establishes patient-centered medical homes are to be supported by community health teams, and those teams are to be interdisciplinary and inter-professional and may include doctors of chiropractic and licensed complementary alternative health providers. There is potential in the law.

Request to the Advisory Group: Dr. Kahn asked the group to request that HHS make available more guidance around Section 2706 to the states and that states be made aware of section 2706. The state

insurance exchanges and essential health benefits package goes into effect on January 1, 2014. She asked the Advisory Group to endorse full implementation of the ACA, which would mean implementation of Section 2706 and that the Council support its implementation and request from HHS guidance for the states. Additionally, she recommended asking DOL to review the charge of the National Healthcare Workforce Commission and to adopt the definition of the healthcare workforce and include licensed CAM professions.

Dr. Kahn stated that it is important to have a vision of health in order to drive efforts, and also with Dr. Ornish's work, there is a long gap between the time when we know something from healthcare data and when that information is ready for adoption and use. For example, since 2007, there have been books with practice guidelines for treating back pain and it still is not showing up many places. It would be important to shorten the time between very persuasive data and broad adoption of low-cost interventions.

Dr. Kahn turned the discussion over to Dr. Ornish.

Dr. Ornish stated that there are two key lessons learned from the White House Commission on Complementary and Alternative Medicine: 1) the importance of achieving agreement within the committee and 2) bipartisan support. Dr. Ornish noted that he wrote an essay (referenced above) with those two lessons in mind. Integrative medicine is about integrating the best of what works. He stated that there is an opportunity now because all of the forces are converging. Limitations of high-tech medicine are becoming clearer. Dr. Ornish gave examples of bypass operations and prostate cancer and noted that conventional treatments are not always the answer and that there is another alternative, which is changing lifestyle. Dr. Ornish noted studies where lifestyle changes resulted in better health outcomes: 1) a randomized trial that found that lifestyle change could stop the progression of early-stage prostate cancer, 2) a series of studies that show a reversal in heart disease for a fraction of the cost, and 3) studies showing that lifestyle change can reduce the risk and sometimes reverse type 2 diabetes. Dr. Ornish noted that drug treatments don't work nearly as well as lifestyle treatments.

He stated that this isn't lifestyle for prevention but lifestyle as treatment. With lifestyle as treatment, a lot of money can be saved in the first year. There is a significant opportunity now with the limitations of high-tech medicine becoming apparent and the power of low-cost, low-tech interventions becoming clearer. He stated that the lifestyle change treatment does not differ — it is the same across diseases and conditions.

Dr. Ornish commented that we can get to the heart of the debate if we can hit on the simple idea to treat the causes, which are the lifestyle choices we make each day. He noted that if lifestyle changes can be made to reduce the incidence of chronic disease at a lesser cost, we can provide better care to more people, and this is a topic that everyone can rally around.

Dr. Levi asked if anyone had questions or comments for Drs. Kahn and Ornish.

Dr. Levi stated that there is the large issue of how quickly we can move from science to practice or the threshold that is set. The threshold for prevention tends to be a lot higher and we see that across the board for many groups. Dr. Levi gave examples of HIV screening and hepatitis guidelines.

Dr. Levi noted that this is an important policy issue and the group should consider whether there is a critical mass of people in the Advisory Group or outside who might take this on to develop structural solutions to the problems. What is the vehicle for saying, “Yes, we have sufficient data for now? There needs to be a structural solution.”

Dr. Levi mentioned the essential health benefits: This issue was punted to the states and that makes it complex to identify a national solution. He noted that there is another vehicle for coverage: essential community providers — anyone offering insurance through the exchanges has to include essential community providers. HHS recently released a [database](#) of essential community providers.

Sister Kerr mentioned the IOM report that stated that 10% of our health is related to the healthcare system and 90% of health is related to everything else. She stated that until there is a conceptual framework, it is difficult to know which way to go or what should be funded.

Dr. Levi stated that this is an important issue and we know that many pieces contribute to health. Given the realities of how many systems we can get to at one time, how do we catalyze more of those relationships coming together? He noted that the needs in each community are very different and asked: what are the catalytic agents that we can identify, that can bring more of these pieces together?

Mr. Johnson asked if one of the catalytic agents is the sobering presentation we heard today from Dr. Woolf and stated that one of the best things we can do is force that awareness in the community.

Dr. Levi wondered if there is a way to be part of enrollment outreach. Can we do something similar to today’s presentations? He noted that we don’t want to just tell people the bad news but that we know how to fix this, we have examples of communities where it is beginning to happen, and we have organizations that can help communities take those next steps. Dr. Levi said that the Advisory Group needs to think about this as part of their public outreach role.

Dr. Seffrin suggested that the NPS needs two pagers that state the value proposition. It will make it more competitive to point out the value proposition of improved health and economic values (cost saving, another year of life, economic output).

Dr. Ornish noted that the other value proposition is to measure not just years of life but quality of life. He mentioned that so much of prevention is fear-based and fear is not sustainable. But feeling good, love, joy, community, and pleasure are sustainable.

Dr. Fielding recommended that they use the paradigm from the 2020 Health Objectives and point out that even behaviors are formed based on the social, physical, and economic environment. It is not inherently genetic. He also mentioned that their recommendations should be based on two things: quality of the evidence and value. He suggested that the group set down the touchstones, values, and core principles.

Ms. Brown wondered about their final objective and mentioned that nothing has been said that we disagree with, but what we are looking for is language and placement about providers and how broad

those providers are. She also mentioned that it is a question of language to determine how we get there. She mentioned that there is a lot we already agree with, but what is the next step in terms of execution?

Dr. Levi agreed and noted that is what needs to be sorted out the following day. He mentioned that there are two things to note: 1) a narrower issue of who is reimbursed and what services are covered, and 2) the broader issue of using health as the starting point and also needing to look from a non-health perspective (housing, transportation, environment, education, etc.). He also noted that the group has been talking around the prevention strategy, but when it comes to implementation of the four strategic directions, are there things that can come from the group up or from the top down that will push people to work in an integrated way?

Dr. Wisdom mentioned that she is not yet hearing anything about the need for demand from consumers. She also noted that provider referral patterns should be consistent with an integrative approach.

Dr. Ornish noted that from the consumer standpoint, more money is spent out-of-pocket for integrative, alternative medicine than traditional medicine and there is clearly demand for it.

3:45–4:30 p.m. Outreach Working Group

Dr. Levi transitioned to the Outreach Working Group.

Ms. Otto provided an update on the Outreach Working Group activities, noting that the group faced some challenges. She mentioned that when the group met to discuss what their charge might be moving forward, Dr. Levi and Dr. Fielding suggested focusing on manageable pieces. She noted that the group decided to focus on enrollment and that the administration, states, and municipalities are focused on this too. Ms. Otto mentioned that the focus is on how we can push prevention in the enrollment process. She mentioned that the group wanted to focus on prevention, health promotion, and integrative public health in the larger enrollment effort.

She mentioned that we will need a concrete set of materials, including a standard powerpoint deck. She suggested working collaboratively with HHS to develop some standard materials for each person in the group to use with his or her constituencies to talk about keeping prevention, health promotion, and integrative public health at the forefront. Ms. Otto gave the example of Cook County, Illinois, which has a waiver and is expanding Medicaid now. She can work with Cook County to educate people on prevention during the enrollment process. She stated that the group discussed using the platform Base Camp to share resources and materials and she offered to give a tutorial on how to use it.

She mentioned that the group had suggested recommendations:

- Promote a more systematic approach to including a population health perspective and engagement in broader community health activities, like CTG.
- Look at how prevention benefits through the ACA could be promoted as part of enrollment activities. The Advisory Group could make the recommendation to HHS that standard materials be made available for training of navigators and in-person assisters.
 - Chicago and Cook County has been building curriculum to supplement what the federal government comes out with for the navigators and the in-person assisters.

Ms. Otto noted that these are preliminary recommendations and feedback is welcome.

Dr. Murthy stated that it is a good idea to focus on enrollment to get the prevention message out. It is important to note that there are not enough resources within the government to drive enrollment efforts and, looking at the experience with Massachusetts healthcare roll-out, it will be community groups doing a lot of the grassroots outreach. Dr. Murthy noted that we should maximize our partnership with those community groups — where are they and who are they are — not just nonprofit, but also private sector.

Ms. Otto stated that since these have to be certified navigators, and if we can make sure prevention is part of the curriculum, then that information becomes part of the training template. The second step will be to make sure that all of the enrollment partners have it.

Dr. Graffunder mentioned that the Advisory Group might make recommendations that each one of the departments touches the communities and may facilitate enrollment and be positioned to be good partners. An explicit statement of what that might look like might be useful.

Dr. Levi discussed next steps for the work the next day and noted that there will be time to discuss the work plan and hone in on the recommendations. He suggested that the group focus on resolving the recommendation language. He mentioned that the group talked about saying something positive to the administration in recognition of their defense of the Prevention and Public Health Fund.

4:30–5:00 p.m. Public Comment

Dr. Levi moved on to the public comment portion of the agenda.

Donna Mazyck, CEO of the National Association of School Nurses (NASN), provided the following comments:

- School nurses are partners in prevention and an invaluable bridge between public health and families.
- School nurses work with 95% of school-aged kids.
- School nurses observe first-hand how culture, poverty, disparities, language, and other social determinants impact children.
- In 2012, NASN developed a visual to help school nurses speak to their communities about the social determinants of health — home and community factors that impact learning.
- School nurses recognize that children come to school with a variety of factors that influence their health.
- School nurses are in a unique position to promote prevention and wellness and research shows the early access to care is vital.
- School nurses serve vulnerable populations by addressing their health risks and promoting healthy life styles.
- Enhanced coordination with local health departments would allow school nurses to provide additional screenings in school.
- NASN has been engaged in conversations on how to work differently and look at integrated models to deliver coordinated care.

- School nurses participated in enrolling children in SCHIP.
- School nurses are valuable members of care coordination teams, facilitating ER visits as well as improving school children's overall health outcomes.
- NASN's priorities intersect with the NPS and they are committed to working together to improve the quality of life for families and children.

Dr. Levi asked for final questions and comments.

Dr. Murthy stated that one thing that might be helpful is for the group to define the scope of what they want to accomplish. What among the many ideas do we want to focus on and what does success look like even in the short term? It would be helpful to craft specific goals for Day 2. Dr. Murthy mentioned that when we talk about integrative health, it's unclear if all of us are talking about the same modalities, and he wondered if it is important to unpack that issue further.

Dr. Swider agreed that it is important to focus on areas that are measurable and said she would also like to talk concretely about anything related to community health and development. She mentioned that one take-away has been how much public health has not been involved in very important conversations that are instrumental in health overall.

Dr. Graffunder made closing announcements around travel reimbursements and completing appropriate forms and an announcement about dinner. She reminded the group that they will reconvene at 8:30 a.m.

Advisory Group on Prevention, Health Promotion and Integrative and Public Health
Friday, March 29, 2013

Welcome and review from Day 1

Dr. Jeffrey Levi welcomed the group for day 2 and roll call was taken.

Present for Day 2: Dr. Regina Benjamin, Richard Binder, Valerie Brown, Jonathan Fielding, Corrinne Graffunder, Patrik Johansson, Jerry Johnson, Janet Kahn, Charlotte Kerr, Jeffrey Levi, Jacob Lozada, Vivek Murthy, Dean Ornish, Barbara Otto, Herminia Palacio, Linda Rosenstock, John Seffrin, Sue Swider, Sharon Van Horn, and Kimberlydawn Wisdom

Dr. Levi reviewed the day's agenda, noting that they would review draft recommendations laid out the previous day, discuss and revise as needed, and vote on them. He asked that they quickly run through the draft recommendations from the previous day for overall context and hold comments, questions, and discussion until after all of the recommendations had been read. He noted that some recommendations are interrelated. The group would also discuss the work plan for moving forward.

Dr. Levi indicated that, as Advisory Group chair, following the meeting he would develop a letter to the National Prevention Council to transmit the resolutions passed rather than put them in a report. Discussion ensued around each of the proposed recommendations and the group discussed, revised and voted upon a final set of recommendation to present to the National Prevention Council.

Proposed Recommendation #1:

We commend the Obama Administration for continuing to defend the Prevention and Public Health Fund. The Fund is critical to furthering our Nation's ability to promote health and prevent disease. As allocations are made for the Fund, we urge the Administration to prioritize those investments that are consistent with the original intent of the Fund: prevention, wellness, and public health activities, including the Community Transformation Grants and outreach and education regarding preventive services newly covered under the Affordable Care Act.

Final Recommendation #1:

The Prevention and Public Health Fund remains critical to furthering our Nation's ability to promote health and prevent disease. As allocations are made for the Fund, we urge the Administration to prioritize those investments that are consistent with the original intent of the Fund: prevention, wellness, and public health activities, including the Community Transformation Grants and outreach and education regarding preventive services newly covered under the Affordable Care Act.

Proposed Recommendation #2:

In our June 26, 2012 report, the Advisory Group recommended, "closer integration of community prevention and lifestyle changes into the Medicare and Medicaid programs, as an important opportunity to both effectively (and less expensively) treat and prevent chronic diseases, such as heart disease and diabetes." We commend the Centers for Medicare and Medicaid Services for issuing a proposed rule (on January 22, 2013) regarding essential health benefits for Medicaid programs that would permit states to reimburse for such services if they are recommended by a licensed provider. We urge the Administration

to finalize this proposed rule and urge CMS and the Centers for Disease Control and Prevention to coordinate efforts to assure effective implementation of this option by state Medicaid programs.

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Proposed Recommendation #3:

The Advisory Group believes that educating the American people about health deficits while also spotlighting successful partnerships from across the country that address the many determinants of health is critical to successful implementation of the National Prevention Strategy. We also believe that it is critical for both the National Prevention Council and the Advisory Group to catalyze more efforts such as those we learned about and invite members of the National Prevention Council to join in a working group with the Advisory Group to identify ways to move forward in this way.

Final Recommendation #3:

The Advisory Group urges the Administration to undertake a national campaign based on the NPS to motivate individuals and mobilize communities to act comprehensively across sectors to address those growing gaps in achievable health status.

The group decided to add a fourth recommendation regarding policies and education to make healthy lifestyle changes as a means of addressing the health and financial burden of chronic diseases. Although this is in the NPS, this would highlight the issue to increase emphasis.

Final Recommendation #4:

In order to reduce the high burden of chronic disease, the Advisory Group urges the Administration to adopt comprehensive policies and education that make it easier for Americans to make healthful lifestyle changes.

Proposed Recommendation #5 pertains to the implementation of section 2706 of the law, which states that it is illegal for any insurer/health insurance plan to discriminate against any provider so long as the provider is acting in their state-licensed/state-certified scope of practice.

Final Recommendation #5:

The Advisory Group endorses the appropriate use of the healthcare workforce as defined in Section 5101 of the ACA. Thus, we request that HHS issues guidance to states regarding compliance with

Section 2706 of the ACA and its relationship to all plans offered through the states' health insurance exchanges.

Proposed Recommendation #6 pertains to the inclusion of a population health approach in implementing new healthcare delivery systems.

Final Recommendation #6:

That the National Prevention Council and HHS (specifically CDC and CMS) assure inclusion of a population health perspective and engagement in broader community health activities when implementing new delivery systems, such as Accountable Care Organizations and Medicaid health homes at the state level.

Proposed Recommendation #7:

That the prevention benefits of the ACA be promoted as a part of enrollment activity, for example, all consumer assistance programs (navigators & in-person assisters in particular) share information about prevention services available.

Final Recommendation #7:

That the prevention benefits of the ACA be promoted as a part of enrollment activity (for example, that all consumer assistance programs include training in all preventive services such as navigators and in-person assisters).

Proposed Recommendation #8:

That the NPC help facilitate enrolment strategies and disseminating information on prevention benefits of the ACA.

Final Recommendation #8:

That the National Prevention Council agencies help facilitate enrollment strategies and disseminate information on prevention benefits under the ACA and that they engage their community partners and grantees in these efforts.

Proposed Recommendation #9:

We urge the collection of sufficient data (including but not limited to gender) to allow evaluation of effectiveness and implementation of ACA in relation to preventive and public health intervention at the individual and community level.

Final Recommendation #9:

We urge the collection of sufficient data (including but not limited to race, ethnicity, gender, and sexual orientation) to allow evaluation of effectiveness of implementation of ACA in relation to preventive and public health intervention at the individual and community level.

General Discussion of Work Plan

Dr. Levi led the group in developing the work plan. He advised that the group look at where it wants to focus and whether the group wants to play an oversight role for implementation of the ACA or be more

active presenting NPS, promoting prevention, and promoting partnerships. If the latter, people need to volunteer to take these on.

He noted two things the group has already talked about that he is willing to take on and help organize. The first is to bring together agencies in the National Prevention Council for an ongoing dialogue. Second, Dr. Levi sent an email to Dr. Woolf about doing presentations and creating more visibility on the good and bad news as a good way to present the IOM report. He asked if that makes sense and how it can be funded. A webinar with Grantmakers in Health (trade association of foundations who do health philanthropy) will take place in April. That's a good place to bring this out. If the member foundations can organize a roundtable or something similar in their communities, this is a good place to bring the IOM report and the strategy and some of the organizations that are representative of the solutions.

Ms. Otto volunteered to help with that effort. She suggested developing a standard presentation to talk about local philanthropy. Dr. Murthy offered to help as well.

Dr. Levi noted that the Robert Wood Johnson Foundation has provided some support. The Advisory Group had volunteers working with the IOM (Drs. Murthy and Wisdom and Ms. Otto), identifying people who have an interest in coming together with National Prevention Council agency reps. Dr. Levi stated that the Kellogg Foundation has offered to support some work in bringing education and health together.

After leading the group in a dance break, Dr. Benjamin noted that creating healthy communities requires working with partners. This partnership needs to happen in the schools. The link between health and learning is very clear; schools really need to support health. There has been a focus in the schools and she asked the chair to convene a working group of the Advisory Group members and other diverse stakeholders to design a framework for a multi-sector public-private partnership to address the four strategic directions of the NPS in schools.

Dr. Levi noted that the Advisory Group has an opportunity to engage stakeholders in the education world who have strong interest in health. Nearly the entire group volunteered to be part of this working group. It will be co-chaired by Rochelle Davis of the Healthy Schools Campaign.

It was suggested that the group lay out the tasks to be undertaken before people commit to helping with any working group. Dr. Levi and the group concurred.

Ms. Otto noted that she likes focusing on multi-sector collaborative to work on a prevention strategy.

Dr. Levi noted that there is foundation support for such an effort. This is designed to bring to the table unions, businesses, parents, teachers, etc.—anyone with a stake in education. It's another way of folding in the broader constituency to understand the NPS. He confirmed that this is for schools in general, K–12, versus schools in areas with high rates of free or subsidized school lunches. This is an opportunity and model for the Advisory Group to do some of its work to bring in outside partners—to engage them and then let go a little. They then report back to the group what they think are the key stimuli or catalysts, what are two or three areas to focus on that would change how schools and health interact, and how the two worlds permanently work together.

Dr. Fielding noted that the evidence is strong on preschool and school readiness by the time children get to kindergarten, so he suggested that this effort include preschool. Another member added that there are already non-government preschool programs like Bright Horizons that are putting a lot of effort/money into this, so we would have partners there.

The next topics Dr. Levi discussed were data—narrowly, in terms of monitoring the ACA, and more broadly, fully understanding health in the community; and shortening the time horizon to diffusion—how do you get from research to practice more quickly?

An Advisory Group member noted one thing that moved to discussion vs. recommendation was setting criteria for what we mean by persuasive and permissible data. Dr. Levi noted that is pulling from research rather than demographics.

Ms. Otto proposed the public engagement working group continue, focusing especially on prevention and enrollment.

Dr. Levi asked Ms. Brown and Dr. Murthy how the Advisory Group can make more explicit the ways in which it engages with policy makers?

Dr. Murthy noted ways the group can educate the public and members of Congress and state legislators about both problems and the solutions to build into communities that need support. First, the group could track what people are doing (meetings, etc.) as part of their non-Prevention Council lives and the Advisory Group can start to coordinate those activities so people can go together. Being proactive, coordinating meetings like that, can ensure that we reach people who need to be spoken to on key Congressional committees, to get representatives from the Advisory Group and members from the community to speak so lawmakers can hear about the problem and pursue solutions

Ms. Brown noted that Base Camp is a good centralized source for looking at what's out there (PPT presentations, etc.). The only way to generate a need for everyone to participate is to ask on a regular basis what people have. It is important to know whom Advisory Group members have talked to and what they have talked about so that everyone is talking about the same things and can piggyback off one another. It would help the group to see how it's being dealt with. It can show that we really walk our talk and more people will know what we've done.

Dr. Murthy posited three elements of public engagement to go forward: 1) reaching out to general public, 2) reaching out to lawmakers, and 3) collecting and aggregating data.

Brigette Ulin, acting director for the Office of the National Prevention Strategy at CDC, noted that she and Mary Beth Bigley will be reaching out to members of the Advisory Group to conduct interviews (with the help of contractor FHI 360) about the work they have been doing since they joined. Ms. Ulin and colleagues want to talk with the Advisory Group more at the meetings and outside the meetings. They will also work to figure out what the group needs from their office in terms of resources and online spaces and they will prioritize what the group needs and how they can support those needs. Ms. Ulin's office has

limited resources, but they can get those for the group. They are working on other activities around addressing the public. It's consistent with everything the Advisory Group is thinking of in terms of public-private partnerships. She will talk with group members and then bring the results of those discussions to the full group.

Ms. Ulin noted that the NPS website has been moved to the Surgeon General's website and that move will be beneficial in the long run. Dr. Benjamin has her own followers, about 60,000 of them, which will become followers of the NPS. They also have a Twitter presence ([@SGRegina](#), [#NPSAction](#)). There's flexibility to do more things under Dr. Benjamin's oversight. They will be enhancing the website and asking for Advisory Group feedback on the site. Dr. Benjamin suggested creating a space on the website for Advisory Group members to put things.

Ms. Brown noted that having the hashtag and the site that group members can direct people to will make a difference. People will share that. She proposed that there be a blog that updates and highlights best practices and what communities are doing. Dr. Benjamin agreed that a blog would be good but noted that they don't have the staff. With the limited support they do have, they want to build out a partners-in-action website which would allow the Advisory Group an easier space to access than a federal space.

Dr. Levi noted that it is a new fiscal year and new contract and that the Surgeon General has heard some of the group's feedback over the last year and the current support reflects a different level than what the group has had. He expressed the group's appreciation.

Dr. Levi asked the group if there was anything else they want to be doing.

Dr. Swider addressed community development. She said she is torn because a lot of the community development is integrated in the other efforts and in recommendations about a national campaign, needs and models, and work with other National Prevention Council members in multi-sectored collaboration. But she believes that looking at multi-sectored partners, considering health more broadly, and focusing on community development is the radical piece.

Dr. Levi suggested that, thinking of the IOM report, as the community health and development working group continues these conversations, one of the strategies would be to replicate the conversation the Advisory Group has been having here. Dr. Swider agreed, as long as they are talking about both looking at the IOM piece and the models. The Federal Reserve says there are sufficient models, but she's not sure that's true or that people would know where to go to find them. Dr. Graffunder summarized the change to say, "Continue the work of the community health and development working group, including the development of strategies."

Dr. Fielding suggested getting external support to hold regional conferences that highlight successes that intersect the work of the Advisory Group, to use national and local conferences as a catalyst. Dr. Levi proposed seeing how initial conversation with Grantmakers in Health goes and how that gets replicated in different communities.

Dr. Levi asked if there are other aspects of the group's charge—with part of it being implementation of the NPS and part oversight of ACA or action plan—that they want to look at more closely.

Dr. Fielding noted that integration of population approaches and individual approaches to health, assumed in the ACOs, is a very important opportunity. Trying to help in that interface is an important opportunity for this group, though he acknowledged he's not sure how much the Advisory Group can take on.

Dr. Levi suggested for the next Advisory Group meeting that they invite people to talk about how public engagement is happening and charged a subgroup of the engagement working group with making a recommendation about how to discuss it at the next meeting.

It was noted that the group has identified the recommendations in the letter, but they have not operationalized all of those recommendations. How does that come about? Dr. Levi said he will indicate in the letter that the Advisory Group has created working groups to look at these more closely.

Dr. Graffunder reminded the group that each working group can only have 11 members at each meeting. Any more makes a quorum for the Advisory Group and all Advisory Group meetings must be public. One group member asked if professionals in other areas can be invited to working groups. Dr. Levi indicated that was permissible and was indeed one of the points of the working groups. The working groups will report back to the full group, who will then make decisions.

Dr. Levi recalled the suggestion under public engagement to have a tracking mechanism to capture who group members are reaching. This group would tee up a discussion at the next meeting on how to integrate population health into new systems like accountable care organizations.

Dr. Levi asked for volunteers for the various working groups.

Community development and health working group (including IOM report): Dr. Swider will chair with Drs. Fielding, Binder, Palacio, Kahn, Rosenstock, and Wilson.

Coming together with agency representatives: Dr. Levi will chair the effort to determine what they are open to.

Education and health: Dr. Fielding, Mr. Johnson, Dr. Palacio, Dr. Seffrin, Dr. Van Horn, Dr. Johansson, Dr. Binder, and Ms. Brown will participate. Dr. Levi noted that the date for their first meeting will be May 1. Some will participate by phone. There is travel money so non-DC folks can attend in person.

Data working group: It was suggested that if the next meeting is the fall, it would be helpful to bring people in for a robust discussion of what's being collected and to identify gaps. Dr. Levi noted that there will be a web-based meeting of the Advisory Group in June and a September face-to-face meeting. If the data discussion is appropriate by phone, that could occur in June. Otherwise, they could do it in September.

Research to practice: The question was raised as to what is meant by "data," and the standard for what findings should be implemented. There are different standards for different issues. Should this be a

recommendation the Advisory Group comes up with after they know more about data collection? One member noted that data collection is more about demographic data. This is more about clinical findings.

Another member asked how much data is already out there and needs to be collated. Dr. Fielding noted that the Community Guide has huge recommendations that have not been adequately disseminated. CDC is working hard with the Task Force to do this, but there are a lot of good evidence-base programs, policies, and practices that are not in place because people have not adopted them and they are not aware of them. These are the best sources of what we know works and what we don't know. It would be nice to have the Advisory Group give a boost to that and make sure everyone is fully knowledgeable and able to speak about that in their efforts. Dr. Swider added that standards exist and efforts are needed to disseminate what's out there.

Ms. Brown noted that she and Dr. Rosenstock are not talking about demographics when speaking about data collection, but data that indicates, for example, the percentage of teens that are obese - data on 150 different health indicators. These data drive the practices put into place. An example was given of recommended practices for the treatment of chronic back pain. There are data to show diagnostics worth doing and not worth doing and what treatments to offer in what order. But those recommendations are not being implemented.

Dr. Levi suggested that this may be a topic where there is not yet sufficient ability to take it on and proposed incorporating a discussion on shortening time from research to practice into the integrative health working group chaired by Dr. Kahn, with Drs. Van Horn and Ornish and Sister Kerr participating. Wayne Jonas will also join this group.

Dr. Levi noted that these working groups are not set in stone. People will be notified of meetings, and if someone who hasn't signed up now decides to join, they can.

Public engagement: Ms. Otto will chair, with Dr. Murthy, Ms. Brown, and Dr. Johansson. Dr. Swider will also join discussions about population health.

Dr. Levi directed members of working groups to work with their chair to invite outside folks to participate. The intention is to invite people who have something to contribute to the discussion and bring additional expertise to the table, not just include people who want to listen in.

Closing Remarks

Dr. Levi thanked the group for their input and noted they had a good agenda for going forward. Before closing the meeting, he suggested coming back to an issue that Dr. Murthy consistently raises: how the Advisory Group can assess itself and not just evaluate others. The group has clarity about the kinds of work it wants to be doing. Dr. Levi asked if group members feel comfortable with this formulation or is there more specificity about how to assess their work product?

Dr. Murthy added that having a self-reflection and evaluation at each meeting is helpful. Having a chance to prioritize the group's engagement is helpful. He suggested that each of the working groups define its

scope of action, goals, and deliverables. In first meeting in working groups, members should define deliverables and what to accomplish before next meeting.

Dr. Swider proposed that having a visual of the formal recommendations and the progress on each would be helpful. Dr. Levi indicated that a spreadsheet can be created.

Dr. Johansson indicated that working in close consultation with the group that will be doing some sort of evaluation, through interviews with key informants from the Advisory Group and CDC, will be important.

Dr. Levi asked if there were any other thoughts to discuss. None were offered.

Dr. Benjamin noted that this [the NPS] is her priority. Reporters often want to know her priority and they want one disease. But it's not one disease and it's hard to convey to reporters how important this is to her. Dr. Benjamin was encouraged to contact Advisory Group members when she comes through their area or have topics to highlight in their area.

Working groups were charged with identifying potential speakers for the next meeting. It was noted that having a significant block of time to hear and engage with speakers works really well. The working groups were encouraged to be integrative in how they bring presenters together.

Dr. Graffunder outlined how recommendations are made to the National Prevention Council. An annual status report on the National Prevention Council is presented to Congress and the President. That status report includes recommendations that come from the Advisory Group and summarizes the Council's actions in response to the recommendations. That's how they get in the public record. The annual status reports are due before July 1 and work is already under way for this year's report.

Dr. Graffunder reminded Advisory Group members to submit paperwork within five days for travel reimbursement. Then she officially adjourned the meeting.