

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
Office of Public Health Preparedness and Response (OPHPR)
Board of Scientific Counselors (BSC)
Summary Report
April 22, 2011 Web Conference

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WEB CONFERENCE AGENDA

Board of Scientific Counselors

Office of Public Health Preparedness and Response

Centers for Disease Control and Prevention

Friday, April 22, 2011

3:00 pm – 5:00 pm (EDT)

Host Location: Roybal Campus, Global Communications Center

Building 19, Rooms 245/246

3:00 – 3:10 p.m. Welcome and Introductions

Barbara Ellis, Ph.D., Associate Director for Science, OPHPR, Designated Federal Official

3:10 – 3:20 p.m. Introductory Remarks

RADM Ali S. Khan, M.D., M.P.H., Director, OPHPR

3:20 – 3:25 p.m. Review of FACA Conflict of Interest Issues

Barbara Ellis, Ph.D., Associate Director for Science, OPHPR, Designated Federal Official

3:25 – 3:55 p.m. Report to BSC on External Peer Review of Division of Emergency Operations (DEO)

Dr. Robert Ursano, BSC Member; Co-Chair, DEO Workgroup

Dr. Louis Rowitz, BSC Member; Co-Chair, DEO Workgroup

3:55 – 4:25 p.m. Discussion and Recommendations

Dr. Robert Ursano, BSC Member; Co-Chair, DEO Workgroup

Dr. Louis Rowitz, BSC Member; Co-Chair, DEO Workgroup

4:25 – 4:35 p.m. Comments from Liaison Representatives

4:35 – 4:40 p.m. Public Comment Period

4:40 – 5:00 p.m. BSC Vote on Recommendations for DEO Review

Barbara Ellis, Ph.D., Associate Director for Science, OPHPR, Designated Federal Official

Updates from Liaison Representatives (time permitting)

5:00 p.m. Adjourn

Barbara Ellis, Ph.D., Associate Director for Science, OPHPR, Designated Federal Official

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WELCOME AND INTRODUCTIONS

Call to Order

Barbara Ellis, Ph.D., Designated Federal Official, Associate Director for Science, Office of Public Health Preparedness and Response

Dr. Barbara Ellis called the meeting to order at 3:01 PM, on April 22, 2011. As the Designated Federal Official (DFO), she initiated the roll call to ensure quorum. Telephone participants dialed in using an audio bridgeline provided. The following Board members were present on the phone: Sharona Hoffman, John Muckstadt, Robert Ursano. Voting ex officio members present on the phone included: Nicole Lurie, Michael Butel, Sally Phillips (DHS ex officio alternate), Lisa Kaplowitz (HHS ex officio alternate), Jesse Geibe (DOD ex officio alternate).

Liaison representatives who were present on the phone included: Mary Gilchrist, James Curran, Damon Arnold, Patricia Quinlisk, and Karen Smith. Other phone participants included: William Waugh and Demetria Gardner. Participants present at the host location included: Barbara Ellis, Louis Rowitz, Dan Sosin, Ali Khan, Philip Navin, Mark Wooster, Clarissa Crawford, Tangela Love, and a number of audience members (see Participant List). Ellen MacKenzie subsequently joined the call at 3:10 PM during the welcome and introductions.

Welcome and Introductions

Dr. Ellis welcomed all participants to the web conference. She stated that the purpose of the meeting was to deliberate and vote on recommendations from the Board of Scientific Counselors (BSC) ad hoc workgroup that was convened to conduct an external peer review of OPHPR's Division of Emergency Operations (DEO). Discussions will be led by the workgroup co-chairs, BSC members and ex officio members.

Dr. Ellis emphasized that it was critical that the voting members remain on the call for the final vote at the end. If anyone needed to leave earlier, they were asked to communicate that need immediately. Sharona Hoffman indicated that she would need to leave once the voting was done and Nicole Lurie would need to leave by 4:30 PM. Dr. Ellis indicated that if the group was not able to complete all of its business in the time allotted, the remaining business would be tabled until the August meeting.

The telephone operator was instructed to mute individuals from the public, who were on the phone until the public comment period. At the conclusion of the meeting, those individuals would be afforded the opportunity to make comments.

Dr. Ellis then introduced RADM Ali Khan and Phil Navin to make a few introductory remarks.

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INTRODUCTORY REMARKS

RADM Ali S. Khan, M.D., M.P.H.,

Director, Office of Public Health Preparedness and Response

Dr. Khan thanked everyone for making their expertise available and emphasized how valuable those capabilities were to this process. Dr. Khan welcomed new ex officio members, including: Dr. Nicole Lurie, Assistant Secretary for Preparedness and Response with the Department of Health and Human Services; COL Michael Butel, Assistant Secretary of Defense for Health Affairs and the Director for Force Health Protection and Readiness with the Department of Defense; and Dr. Alexander Garza is the Assistant Secretary for Health Affairs and Chief Medical Officer with the Department of Homeland Security. Dr. Garza was unable to participate so Dr. Sally Phillips from DHS' Office of Health Affairs participated as his alternate. These senior leaders, he indicated, help CDC to work better across agencies to accomplish the goal of securing the health of the nation.

There are five new BSC members that have recently accepted invitations to serve on the Board including: Donald S. Burke, Dean, Graduate School of Public Health, University of Pittsburgh, Pittsburgh; Thomas V. Inglesby, (Chair), Director of the Center for Biosecurity of University of Pennsylvania Medical Center, Baltimore; John R. Lumpkin, Senior Vice President and Director of the Health Care Group, Robert Wood Johnson Foundation, Princeton, NJ; Herminia Palacio, Executive Director, Harris County Public Health and Environmental Services, Houston, Texas; and Elaine Vaughan, Professor Emerita of Psychology and Social Behavior, University of California Irvine, Irvine, CA. All have accepted their new roles and will be joining the present members to help broaden their scope of expertise. Dr. Khan indicated that he hopes to have all new and existing members together in the upcoming BSC meeting this Fall.

Dr. Khan stated that at his request, OPHPR is undergoing CDC-wide public health preparedness and response strategic planning. OPHPR is still in a fairly early stage of the planning, however we will be engaging the BSC to get their input in the near future. Currently, OPHPR is in the midst of anthrax preparedness. Dr. Khan stated that one of his priorities is to make sure OPHPR's response is as good as it can be for preparedness so that it may support state and local agencies. He looked forward to hearing suggestions on how OPHPR may effectively meet this goal.

Except for 11 days, the CDC Emergency Operations Center (EOC), managed by DEO, has been activated continuously since 2009 to support the CDC Incident Management System. It was only deactivated 4 days ago at the conclusion of the Japan earthquake and tsunami disaster response. There have been several major responses since 2009 such as H1N1, cholera and earthquake in Haiti, earthquake and tsunami in Japan, and the Deep Water Horizon oil spill.

The Emergency Operations Center is instrumental in responses to emergencies. Dr. Khan compared the present state of the EOC to one year prior. He recognized that many changes had occurred, and there is evidence that EOC is starting to work differently. He further underscored that some of the most dedicated officials are those in the EOC. Dr. Khan extended his personal thanks to DEO senior leadership headed by Phil Navin and then turned to him for a few remarks.

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Phil Navin, MHA

Director, Division of Emergency Operations

Office of Public Health Preparedness and Response

Mr. Navin thanked everyone for being present at the meeting. He indicated that he's been a part of the DEO for 8 years and that DEO had just celebrated its anniversary. DEO started back in January 2010 and has had many responses since then. It has also improved many of its processes. Mr. Navin indicated that there were a number of people who contributed to the improvements seen in DEO including Dr. Lurie and that the DEO must continue to adjust and improve based on lessons learned.

There have been 40 incidents that have occurred since DEO's existence 8 years ago, and with the new Presidential Policy Directive, which includes a new national preparedness system, even more changes and improvements are to come. He thanked everyone for their continued interest and energy on this project, and looked forward to hearing the groups' input on the DEO's processes.

Before proceeding, Dr. Ellis asked for a final roll call to ensure that quorum was achieved. Dr. Ellen MacKenzie was present and the meeting could proceed.

REVIEW OF FACA CONFLICT OF INTEREST ISSUES

Barbara Ellis, Ph.D., Designated Federal Official

Associate Director for Science

Office of Public Health Preparedness and Response

Discussion:

Dr. Ellis said that all members of the board have served on external review workgroups, and she was thankful for their efforts. Dr. Ellis stated that the goal of these efforts is to help create and support a transparent, multi-disciplinary process for external expert review and improve OPHPR's capacity to continuously improve processes, programs, and vision through the input of the Board. Dr. Ellis reviewed the description of duties from the BSC charter. With regard to disclosure, the goal in appointing members to our Board is to achieve the greatest level of expertise, while minimizing the potential for actual or perceived conflicts of interest. For certain interests that potentially enhance the Board members' expertise while serving on the committee, CDC has issued limited conflict of interest waivers. Members with conflicts of interest may serve as consultants to present to the Board on certain matters; however, they are prohibited from participating in deliberations or committee votes on these matters.

Dr. Ellis then asked if there were any board members that would like to identify a conflict of interest at this time. The Board members' lines were opened and all others muted. No conflicts of interest were indicated. She also asked if all members had received the complete list of recommendations. No one indicated that they had not.

Dr. Ellis then turned the meeting over to Dr. Ursano and Dr. Rowitz to provide an overview of the DEO review before the BSC deliberates on their observations and recommendations prior to a final BSC vote on the recommendations.

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REPORT TO BSC ON EXTERNAL PEER REVIEW OF DIVISION OF EMERGENCY OPERATIONS (DEO)

Dr. Robert Ursano
BSC Member, Co-Chair, DEO Workgroup

Dr. Ursano expressed his pleasure to be present for the web conference. He also thanked Mr. Navin, RADM Khan, and Dr. Ellis for all their efforts. He said that the workgroup was a

wonderful group to work with, along with CDC and the Division to address national preparedness issues.

Dr. Ursano then provided a little background about the workgroup and its membership. The workgroup started its work a little more than a year ago. There was a tremendous amount of work that went into bringing the group up to speed and preparing it for the challenges that would be faced. A pre-meeting webinar was held on January 19 to provide an overview of DEO, CDC's response mission, EOC utilization and activation, and the Director's Critical Information Requirements (DCIR) concept. There was a two-and-one-half day, in-person meeting in Atlanta, January 26-28, 2010. At that meeting the workgroup was able to hear from the EOC stakeholders and four internal stakeholder focus group panels, listen to DEO presentations and review key documents. He expressed that it was a wonderful exchange with open dialogue and a substantial number of questions.

As the group began to look at specific areas, there were key questions that arose. The questions were centered on eight focus areas including: barriers, EOC facility and work environment, EOC procedures and services, feedback mechanisms, training, metrics, Director's Critical Information Requirements (DCIR), and information prioritization framework. From the review, 48 recommendations were made within these eight focus areas. Dr. Ursano proceeded to present the first four focus areas along with the workgroup's recommendations for each.

Barriers: What are the significant barriers to utilization or activation of the CDC EOC by internal stakeholders? What are your recommendations for mitigating or eliminating these barriers?

Recommendations:

1. Regular (e.g., quarterly) meetings between DEO and divisions or branches that are frequent users of the EOC to obtain feedback, promote services, develop stronger interpersonal relationships, and build trust. EOC feedback at the Division Directors' meeting would also be a mechanism for this information sharing. Similar meetings may take place between DEO and occasional users of the EOC as necessary. This type of outreach seems essential, and it is important for DEO to meet agency components on their turf rather than having them always come to the EOC.
2. Establish an internal stakeholder working group to provide input to DEO. Such a working group should consist of members of the CDC components that are heavy users of EOC services, and should meet on a monthly or bimonthly basis. Such a group could go a long way to develop stakeholder support for the EOC. However, for this group to

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be most effective there should be clear evidence that efforts are being made to implement the recommendations made by the working group to DEO.

3. Continue to demonstrate flexibility in using the EOC, and make sure stakeholders understand the flexibility and the services that are available. This can take the form of a menu (or suite) of services that are available from DEO short of formal activation. Placing such a list on the website would assist in this process. This will bring components of CDC to the table earlier, and hopefully allow early phases of a response to be more effective for DEO and for the program.

4. For the CDC Director's action and the DEO: there should be a clear understanding among all CDC components that complex responses are managed through the EOC structure. This message needs to come unambiguously from the overall leadership of

CDC and the leadership of the various organizational components.

EOC Facilities and Work Environment: What changes or modifications to CDC EOC facilities and work environment would be expected to increase the willingness of internal stakeholders to utilize the CDC EOC or request its activation for response to a public health incident?

Recommendations:

5. The workgroup recommends that the CDC Director initiate efforts to address life-style concerns. While a “concierge” function seems anathema to an emergency response, it should probably be a core component of the facility to support those working there. This would include assuring access to healthy meal options (either by having food made available directly by DEO, assuring after-hours access to the cafeteria, or obtaining food from outside sources), and maintaining a designated stress reduction or rest area. The DEO should work with facilities management to either block a number of parking spaces for response personnel or have a shuttle service available for off-site parking. Easily accessible meeting rooms and work areas for teams away from the main EOC would be beneficial (possible to include taking over rooms in the global communications center for large-scale activations). Noise mitigation efforts should also be assessed. This is further addressed in recommendations 12, 13 and 14 below.

6. While a backup EOC exists in Lawrenceville, this location is not especially convenient for most Atlanta-based CDC components. Although expensive, the workgroup recommends that the CDC Director consider a smaller, but full-service additional EOC on the Chamblee campus. EOC satellite facilities should also be considered for the non-Atlanta locations, especially NIOSH and Fort Collins where it is impractical, expensive, and bad for morale for staff to come to Atlanta for extended periods.

7. To reduce the number of individuals physically present in the EOC when activated, alternative models should be developed for participation via a “virtual” EOC. Present activities to develop virtual EOC procedures and software address this issue and should be moved forward. This would also likely enhance the willingness of personnel to participate in a response and would reduce stress. Such an approach would allow responders to participate from their usual work location, or when necessary from home or the field. It is especially helpful for those who may need to be engaged episodically or briefly, or those located on other campuses or outside of Atlanta. This is further discussed in recommendations 10 and 11. The workgroup observed that expanding the

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physical size of the current EOC on the Roybal campus seems unwarranted, especially if some of the approaches above can be implemented.

8. EOC Working Space Availability:

a. Review and make changes to the layout of the EOC to increase its flexibility and utilization for essential functions. Consideration may be given to modularized organization which may better enable flexible multiple event EOC response.

b. Move from the EOC physical space those functions that can be handled effectively by virtual participation.

c. Make site visits to well-regarded EOCs elsewhere in the nation that use alternative arrangements of organization to assess the feasibility of using these approaches at CDC (e.g., EOCs that do not use the mission-control style). For example, an alternative for the main floor would be a shift to laptop

computers on moveable tables that can be separated or clustered as needed to suit the requirements of effective response to a given incident. Greater flexibility in layout of the EOC also would create the potential to separate groups responding to different, concurrent incidents within the space of the EOC main floor. A priority in space should be the application of space released for new uses to respond to now-inadequately met mission needs. Notable among these are expansion of the confined area for the JIC and creation of additional quiet areas for focused preparation of briefings and reports.

d. The OPHPR Director should address the issues of noise by examining the feasibility of implementing the previously developed sound deadening plan for the EOC main room.

9. CDC buildings and facilities operations should address issues with the HVAC environment: Identify and implement improvements to the heating, ventilation, and air conditioning throughout the EOC.

10. Virtual Emergency Management: Develop a plan to maximize the use of virtual coordination, collaboration, decision-making, and administration for the array of CDC emergency management approaches from short-duration, limited-scale incidents to extended, enterprise-level incidents. CDC's management of emergencies in many instances is an enterprise endeavor in which the EOC itself is only one component. CDC's capacity, agility, and effectiveness in emergency management would likely be enhanced through application of existing, proven virtual systems. Most significant is the potential to facilitate and improve the insight and quality of collaborative decision making by virtual means that engage stakeholders across CDC as needed. A collateral benefit should be reducing the need for subject matter experts (SMEs) to relocate physically to the EOC for an incident. Achievement of effective virtual collaboration and decision making should increase the number of incidents that are addressed effectively by CDC short of activating the EOC. Commonly cited inhibiting factors in use of the EOC, such as tracking of personnel and their relevant capabilities, can be reduced by other complementary IT-based systems. These actions may also result in improved emergency management outcomes, a higher level of CDC participant satisfaction, and lower financial cost to CDC.

11. Explore the value/cost savings/issues of virtual capabilities (coordination, collaboration) for present EOC (Atlanta). Explore the value/cost savings/issues of satellite EOCs for

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places not on Clifton Road (e.g., Chamblee or Fort Collins). This will be addressed via a cost benefit analysis.

12. The CDC senior leadership needs to engage appropriate facilities management components of CDC to develop and implement plans to address:

- o Parking: Consideration should be given to blocking a group of parking spaces reserved for personnel deployed to the EOC during an activation or other emergency response, especially for those not usually located on the Roybal campus.
- o Food Service: Reliable solutions are needed for 24-hour food service during an activation to include healthy and nutritious food options.
- o Hygiene and rest: Options should be developed and implemented to assure adequate access to shower, bathroom, and rest areas during an activation.

EOC Procedures: What procedural changes from those outlined in CDC's Emergency Operations Plan would increase internal stakeholder activation or utilization of the CDC EOC?

Recommendations:

13. A "human resources" (HR) activity should be built into the EOC. Such an activity would help orient personnel as they come into the EOC, and could include the "concierge" function mentioned above. The HR function would also have responsibility for keeping formal rosters of available staff for any response. At present, the rostering function appears relatively ad hoc. The HR component would also be responsible for debriefing personnel when they finish their tour of duty in the EOC.

14. There needs to be more structured procedures for deactivation of a response. In NIMS, deactivation is a responsibility for the planning section and begins almost immediately. However, since many CDC activations use a modified NIMS structure, deactivation may not be as formalized. It appears that most responses simply "run out of steam" rather than end through systematic planning. This is important for those involved in the response, because otherwise the activity appears needlessly open ended.

15. Every individual who takes part in a response needs to have clear time frames for the duration of their involvement (i.e., a set tour of duty). Too often the duration of an assignment is unclear or is extended, and this uncertainty decreases the level of enthusiasm to take part in emergency responses. The analogy is uncertain deployments or repeated deployments in the military and the effect this has had on morale.

16. The EOC needs to systematically evaluate which functions need to be physically present in the EOC and which can be done remotely. There is no need to use seats in the EOC for groups that are needed sporadically or for minimal periods of time. This results in either empty desks or individuals who are sitting around doing their normal work from the EOC. This wastes space and resources.

17. Because events that do not reach the level of EOC involvement may be worked outside the EOC at program levels, it is important to develop a standard and centralized process for programs to inform the EOC of events being worked outside of the EOC to ensure communication flow is both out of and into the EOC.

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EOC Services: What services could DEO provide to internal stakeholders that would be expected to increase the utilization or activation of the CDC EOC?

Recommendations:

18. A task force should review resources and capabilities (IT tools) for sustaining EOC situational awareness capabilities (e.g., data mining, visualization). This is a rapidly growing area that will require ongoing development and review to stay current and be most useful to the EOC.

19. The DEO should examine the possible benefits to EOC and program coordination of social networking as a component of building collaborative operations with programs.

20. As stated above, the DEO should develop and maintain virtual networks to expand the CDC's linkages among campuses and with external stakeholders.

Feedback Mechanisms: What improvements can be made in addition to the After Action

Review (AAR) process to obtain feedback from CDC EOC internal stakeholders?

Recommendations:

21. In-progress action reports. For prolonged activations, there should be periodic “in-progress” reviews to make sure course changes and corrective actions can be taken during the response rather than waiting until it has ended. This would be a periodic “pulse check” to identify problems and issues. It is suggested that an in-progress review be done monthly for prolonged responses.

22. All persons engaged in a response should be debriefed at the time their tour of duty ends (see also recommendation 16 above). This debriefing can be done face-to-face, or could be a web-based survey that is completed as part of out-processing. It allows everyone to contribute to feedback, especially when the experience is freshest in their mind.

23. The stakeholder survey conducted in the fall of 2009 should be repeated on a periodic basis and trends in satisfaction should be measured. As a suggestion, the survey (or a simplified version of it) should be done annually. Results should be distributed.

24. AARs play an important role in an EOC. It is recommended that a specific, separate review be undertaken for the AAR to identify any corrective actions necessary to ensure that AARs are having their intended impact.

25. An external customer survey should also be accomplished. This would include stakeholders such as states, Federal departments, international partners, NGOs, and private sector partners.

26. Consideration should be given to establishing a standing technical advisory group of SMEs from the CDC organizational components most likely to use the EOC. Note that this is specifically SMEs not only those engaged in the emergency operation but individuals who can contribute knowledge of how their subject area operates in the field to enhance SME-EOC collaboration and knowledge from SMEs to EOC (see also recommendation 2).

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27. A suggestion box in the EOC for users (provide confidential feedback mechanism).

Dr. Louis Rowitz
BSC Member, Co-Chair, DEO Workgroup

Dr. Rowitz presented the remaining four focus areas along with recommendations for each. He asked the Board to frame their thinking around the 8 focus area rather than individually since there were 48 recommendations.

Training: What additional training from that outlined by OPHPR’s Learning Office needs to be provided or improved to facilitate CDC EOC utilization or activation?

Recommendations:

28. CDC should identify those individuals likely to lead or play a major function in emergency response or EOC activation. Such individuals should be fully certified in NIMS and such certification should be documented. Mandatory NIMS training is required for personnel in accordance with the tier system already in place.

29. An EOC training video would be helpful, not only for internal stakeholders but also for external stakeholders. This video (or videos) may address increasing knowledge about the EOC, marketing of the EOC and orientation for new personnel. Such a video will require good production qualities to be useful. Such a product may also help to reduce the large number of tours currently given of the EOC. This is distracting to personnel working there and also consumes valuable staff time.

30. A cross-training plan should be developed for EOC staff and responders. It is recognized that the bench strength may not be deep in a number of areas. If illness occurs or positions are vacant, there may be insufficient personnel with the depth of knowledge necessary for 24-hour coverage of a position or activity. Maximizing cross-training within EOC sections can facilitate increased ability to surge and enhance information sharing. Familiarization and liaison activities across functions in the EOC will also facilitate and increase understanding, team function, information sharing and participation.

31. It is important to continue the operational plan for which prolonged activations employ rotating incident commanders. This also assists in training a cadre of personnel with the necessary skills.

32. Training for operating in the EOC should be developed to match the job and responsibilities of the individuals involved and not only be general or command structure only knowledge.

33. Personnel training policies should be reviewed to ensure that appropriate career training or mentoring is available and used to develop these skilled individuals. More generally, leadership and management skills may be increasingly necessary for CDC personnel to address the response capabilities for the agency.

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34. EOC training and service across CDC should be incentivized using formal and informal policy (e.g., awards, recognition). Training requirements should be part of the personnel position descriptions and evaluation process. Position descriptions should include roles expected to be performed in the incident management system. A job category for emergency management personnel across levels of skill and seniority is needed.

Metrics: How best can DEO measure the success of its efforts to support internal stakeholders? How best can DEO measure impact of its efforts to support internal stakeholders?

Recommendations:

35. Conduct an in-depth analysis of several activations/responses to measure the potential impact and cost savings that accrued from operating within the EOC/emergency response framework. The methodology for such an evaluation should be worked out with an objective external party(s).

36. Periodically repeat the stakeholder survey done in the fall of 2009 to measure trends in satisfaction, knowledge, and attitudes regarding the EOC (see recommendation 26 above).

37. As in recommendation 15 above, operationally debriefing will also provide important metrics. The workgroup recommends debriefing EOC users at the end of their tour of duty and measuring their satisfaction with their deployment to the EOC.

38. Measure utilization of the EOC by organizational entity, type of response, number of responders, and duration.

Director's Critical Information Requirements (DCIR) Strengths and Weaknesses: What are the strengths and weaknesses of the DCIR framework as it is currently used to facilitate the upward flow of actionable information to CDC leadership?

Recommendations:

39. DCIRs are one communication tool. There are others which are also highly valued for providing information vertically and horizontally. It is important to identify and prioritize all communication tools that enable both leadership and operators to stay informed.

40. The CDC Director's Office and Centers should identify essential elements of information and tools to inform the EOC of information they believe is most important to EOC and CDC-wide emergency operations.

41. Create a DCIR review/creation process if it has not already been done.

42. DCIRs should be refined in an ongoing manner to reflect the critical information that should be reported to the Director and when the director should be called to alert of an event.

43. DCIRs should be carefully constructed to reflect specific needs and events and named for each event.

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44. When DCIRs are modified they should also have a dissemination plan and a plan for when they will be reviewed.

45. The DCIR development process should be created with input from the SMEs staffing the EOC.

Information Prioritization Framework: What framework should be used for the prioritization and reporting of public health incident information up the chain of command during a response in order to provide actionable information to CDC leadership?

Recommendations:

46. The CDC Director and OPHPR should initiate a five year strategic planning cycle for the EOC as a component of the CDC's preparedness and response mission. Staff this initiative to include a cross-section of stakeholders who will own and implement the resulting strategic plan. The planning process can be an organizing framework for evaluating and acting on many of the observations and recommendations in this review.

47. Refine the enterprise-level CDC Emergency Operations Plan to include virtual collaboration and decision-making, and networked EOCs to include vision, mission, goals, objectives and measures of evaluation. It is important that the EOC strategic plan be integrated to the enterprise wide plan.

48. As part of the strategic planning process, an internal and external stakeholder analysis (states and local governmental partners and any relevant business, professional organizations, and not-for profit partners) should be part of the process.

Dr. Robert Ursano
Dr. Louis Rowitz
BSC Members, Co-Chairs, DEO Workgroup

Dr. Rowitz then opened the discussion up for the BSC members' comments and questions.

S. Hoffman: My only question is whether we actually want to approve all 48 recommendations. In the past, we were told to be careful because these recommendations can be binding on the agency and can cause future problems with compliance. Maybe we can do the most important ones that can be accomplished quickly. After a year, they may only be able to address a few and with the economy and financial cutbacks, we may not want to do all 48. These can be resource intensive.

P. Quinlisk: These recommendations seem to be at very different levels, some critical and some not immediately necessary. Was there any prioritization done or should there be?

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R. Ursano: The process that you are seeing is a result of multiple weeks and months after the meeting, mail-outs, rewrites, and conversations with a much larger group to eliminate redundancies. So these are targeted to those points that are most important. I appreciate the concern, but I think the task is to identify and make recommendations. Then the programs are tasked to figure out what they can or cannot do. That is a complex issue, but we are to identify the areas of change only.

N. Lurie: This was well done and is an impressive body of work. Some of these are about the EOC and some about the quality of response. I wonder if we should prioritize this and focus on those related to the EOC at this point?

L. Rowitz: Dr. Khan do you think it is too much detail or do we need more collapsing?

A. Khan: I was going to say how well this was done and you have put together a set of detailed actionable items. I am quite sure to take Dr. Lurie's comment into account, we should prioritize to what is going to be the most effective response first, and Phil will further prioritize. But it would be nice to have additional guidance on some of the key things. Phil do you have comments?

P. Navin: All the recommendations touch every area in some ways and are applicable, but if we could get the Board to narrow the focus it would be helpful.

D. Arnold: In H1N1, we ran into issues of people's family management structure when on-call. We need to figure out how to address those issues better. People are not able to communicate effectively with their families during a long activation. Overseas they were able to keep in touch via the internet. So that was one comment on the area to the family structure that may also be considered.

L. Rowitz: Why don't we talk about these in terms of the 8 focus areas and start there. Some are already in progress or completed, so that puts us below 48. The first is the barrier focus area, and 2 of the 4 recommendations have already been completed. Are there any discussions on barriers?

N. Lurie: It seems as though there's a sense that EOC is underused. I'm wondering do you still have that sense and that there's still major barriers or have those evaporated?

P. Navin: Actually the sense is that the EOC is actively used, and sometimes we can't get people out of there. We currently have a call center active and we are still working on the Haiti response. More people are recognizing its usefulness and therefore using it more. We continue to do more orientation, so a lot more people are learning about it. We just finished a tour.

R. Ursano: In the report done last year, it was presented that there was a perception of underutilization, but that did not bear out in the review. So Phil your comments are in support of that.

B. Ellis: There was a point raised about historical barriers, but we have seen incredible improvements particularly with the use of subject matter experts (SME).

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S. Hoffman: So do we still need recommendations 3 and 4 since 1 and 2 have been implemented?

L. Rowitz: The issue with number 4 is to gain clarification so that the CDC Director knows what's going on with the EOC. There were people that were honest about people not knowing what EOC does, and the agency as a whole needs to support some of these activities.

R. Ursano: I would echo that.

P. Navin: Yes, that perception is no longer the case.

L. Rowitz: Are there any discussions on recommendations 5 through 12. There was a great deal of discussion about 12 related to food and those on a 24-hour command needed to have that area addressed along with rest and parking. There was thought that the agency may not be aware of these issues.

N. Lurie: I would like to endorse the importance of this and some of the associated recommendations. I also would not suggest being there for more than 24 hours because it's not conducive to good decision-making.

R. Ursano: We were not given the task of considering budgetary issues. That is for the agency to look at. If that be the case, then we need to look at that with all issues.

S. Hoffman: In prior reviews we were told to have consideration for actionable recommendations because there were consequences for those that were unrealistic. Do we as a BSC need to be sensitive to those issues? Can we get guidance on whether we can make recommendations and let CDC prioritize those?

B. Ellis: The hallmarks of a good review are outcomes in terms of recommendations that are implementable. When this workgroup met, discussions around budget were not as critical as they are now. We will defer to you all on that. There are some recommendations that require consideration of resources and funds.

For example, recommendation 12 has been an issue for years now. It is up to the program to determine if they can or cannot be implemented at this time due to budget constraints.

D. Sosin: Since I have a certain amount of responsibility for how this group got started, we wanted to hear all the points that could improve our response capabilities. We need to get these ideas out. For example, we would love to put another location at the Chamblee campus and that would help significantly, but it is not feasible right now. The program response is the place to say we would love to do these things, we have the recommendations in our sights, and the program will parse out those that we can do at this time.

L. Rowitz: We could say for those recommendations that cannot be done, what is the argument for why they cannot be done at this time.

M. Butel: Recommendations 7, 8b, and 10 can be more under 16. We can combine recommendations there.

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B. Ellis: You are pointing out that some recommendations have some overlap. Since this was the ad hoc group, we thought it not suitable to change those at the time, but we would bring those overlapping recommendations to the Board's attention.

S. Phillips: I also had similar concerns regarding fiscal impact, but the intent of the group was to recommend that this is the best way to do this and how it gets done is in the capacity of CDC.

L. Rowitz: What about comments on the EOC procedures and services, recommendations 13-20?

M. Gilchrist: In recommendation 18, I was impressed with the data mining aspect. Previously there was some inefficiency with delivery of data to CDC and getting information back in real-time. Data mining is a good one, so I am really in favor of this one.

J. Muckstadt: With the advancing technology do we need to have so many people to physically report? Can it be done in a virtual sense if we use IT tools more effectively?

L. Rowitz: Yes there is some overlap with the recommendations and some of these may include things such as virtual, social networking and face-to-face approaches.

R. Ursano: We are exploring some additional ways that it could be helpful.

M Butel: Regarding recommendation #15, tour of duty, would the CDC Director have control over the EOC tours of duty?

M. Wooster: This is usually handled by the individual's supervisor.

D. Sosin: When needed, the CDC Director sets expectations for longer tours when needed.

L. Rowitz: Any comments on recommendations for training, 28-34? Recommendation number 28 has been completed. Training was also brought up as far as leadership or management that might need some additional management training. Any comments?

[No response]

Regarding metrics, three are being addressed, but 35 still needs to be addressed. Any comments?

[No response]

Regarding DCIR strengths and weaknesses recommendation, one is partially addressed, number 41. Any comments?

[No response]

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And finally, recommendations on the information prioritization framework. Are there any comments?

S. Hoffman: I want to emphasize how thoughtful these recommendations are, but do we need to consider the developments in the last year that emphasize how the EOC should operate?

A. Khan: That is an excellent comment. There has been significant maturation since this review was held that addresses many of the action items and you see that reflected. Phil and Mark were being very cautious of what was completed and what was partial.

R. Ursano: We could ask the office to present the five-year plan to the EOC.

A. Khan: The EOC planning is independent.

M. Wooster: We have a plan for EOC, but in the context of these recommendations, we need a plan for the Division as a whole.

L. Rowitz: Perhaps a more realistic approach would be a four-year plan. Any other comments? Bob any comments after the discussion?

R. Ursano: I think these are some excellent recommendation and hopefully this leads to better functioning of the EOC as a part of our national security.

COMMENTS FROM LIAISON REPRESENTATIVES

Dr. Rowitz solicited comments from the Liaison Representatives.

D. Arnold: A lot of emphasis has been toward accreditation for people to function in their roles. I am looking at this from a state's perspective and how do you deal with the states and their different laws and processes, the flexibility component. How does the EOC deal with different inputs from these different arenas?

K. Smith: I really appreciated the amount of work that went into carefully looking at the

EOC. I have had a chance to work with the EOC in the Haiti response and the individuals who came through the Ministry of Health. The EOC recognized that the 2-week deployment was not working and rapidly moved to a different paradigm. This is indicative of working with a well-functioning EOC. EOC is a great resource and will be even better with the implementation of these recommendations.

P. Quinlisk: I second those earlier comments and I am very impressed with this review.

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PUBLIC COMMENT PERIOD

Dr. Ellis solicited comments from members of the public that were on the phone.

B. Waugh: I would like to comment on the suggestion for other EOC facilities. You need another area to go to like a conference room, but something far more developed than what we presently have.

P. Navin: Bill, I appreciate your comment. There are facilities that have been converted for conferences with computer and telephone access, etc., in case we need to go to a different location. There are continuity of operations facilities north and south of Atlanta as well as video teleconferencing at Chamblee campus in the event for small contingencies.

There were neither any further comments from the public nor any comments from individuals in the host room location.

BSC VOTE ON RECOMMENDATIONS FOR DEO REVIEW

Barbara Ellis, Ph.D., Designated Federal Official
Associate Director for Science, Office of Public Health Preparedness and Response

B. Ellis: Before the BSC votes, are there any other concerns or questions?

[No response]

The vote will be by focus area. Any comments or questions about the approach? If there are any recommendations that you'd like to move to the August meeting you can note that as we are moving along. So the first vote is barriers.

Focus Area: Barriers, Recommendations (1-4)

1. Regular (e.g., quarterly) meetings between DEO and divisions/branches that are frequent users of the EOC to obtain feedback, promote services, develop stronger interpersonal relationships, and build trust. EOC feedback at the Division Directors' meeting would also be a mechanism for this information sharing. Similar meetings may take place between DEO and occasional users of the EOC as necessary. This type of outreach seems essential, and it is important for DEO to meet agency components on their turf rather than having them always come to the EOC.

2. Establish an internal stakeholder working group to provide input to DEO. Such a working group should consist of members of the CDC components that are heavy users of EOC services, and should meet on a monthly or bimonthly basis. Such a group could go a long way to develop stakeholder support for the EOC. However, for this group to be most

effective there should be clear evidence that efforts are being made to implement the recommendations made by the working group to DEO.

3. Continue to demonstrate flexibility in using the EOC, and make sure stakeholders understand the flexibility and the services that are available. This can take the form of a menu (or suite) of services that are available from DEO short of formal activation. Placing such a list on the website would assist in this process. This will bring

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components of CDC to the table earlier, and hopefully allow early phases of a response to be more effective for DEO and for the program.

4. For the CDC Director's action and the DEO: there should be a clear understanding among all CDC components that complex responses are managed through the EOC structure. This message needs to come unambiguously from the overall leadership of CDC and the leadership of the various organizational components.

Discussion:
No discussion.

Motion and vote to approve: recommendations (1-4)

S. Hoffman: Yes
E. MacKenzie: Yes
J. Muckstadt: Yes
L. Rowitz: Yes
R. Ursano: Yes
L. Kaplowitz: Yes
M. Butel: Yes
S. Phillips: Yes

Focus Area: EOC Facilities and Work Environment, Recommendations (5-12)

5. The workgroup recommends that the CDC Director initiate efforts to address life-style concerns. While a "concierge" function seems anathema to an emergency response, it should probably be a core component of the facility to support those working there. This would include assuring access to healthy meal options (either by having food made available directly by DEO, assuring after-hours access to the cafeteria, or obtaining food from outside sources), and maintaining a designated stress reduction/rest area. The DEO should work with facilities management to either block a number of parking spaces for response personnel or have a shuttle service available for off-site parking. Easily accessible meeting rooms/work areas for teams away from the main EOC would be beneficial (possible to include taking over rooms in the global communications center for large-scale activations). Noise mitigation efforts should also be assessed. This is further addressed in recommendations 12, 13 and 14 below.

6. While a backup EOC exists in Lawrenceville, this location is not especially convenient for most Atlanta-based CDC components. Although expensive, the workgroup recommends that the CDC Director consider a smaller, but full-service additional EOC on the Chamblee campus. EOC satellite facilities should also be considered for the non-Atlanta locations, especially NIOSH and Fort Collins where it is impractical, expensive, and bad for morale for staff to come to Atlanta for extended periods.

7. To reduce the number of individuals physically present in the EOC when activated, alternative models should be developed for participation via a “virtual” EOC. Present activities to develop virtual EOC procedures and software address this issue and should be moved forward. This would also likely enhance the willingness of personnel to participate in a response and would reduce stress. Such an approach would allow

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responders to participate from their usual work location, or when necessary from home or the field. It is especially helpful for those who may need to be engaged episodically or briefly, or those located on other campuses or outside of Atlanta. This is further discussed in recommendations 10 and 11. The workgroup observed that expanding the physical size of the current EOC on the Roybal campus seems unwarranted, especially if some of the approaches above can be implemented.

8. EOC Working Space Availability:

a. Review and make changes to the layout of the EOC to increase its flexibility and utilization for essential functions. Consideration may be given to modularized organization which may better enable flexible multiple event EOC response.

b. Move from the EOC physical space those functions that can be handled effectively by virtual participation.

c. Make site visits to well-regarded EOCs elsewhere in the nation that use alternative arrangements of organization to assess the feasibility of using these approaches at CDC (e.g., EOCs that do not use the mission-control style). For example, an alternative for the main floor would be a shift to laptop computers on moveable tables that can be separated or clustered as needed to suit the requirements of effective response to a given incident. Greater flexibility in layout of the EOC also would create the potential to separate groups responding to different, concurrent incidents within the space of the EOC main floor. A priority in space should be the application of space released for new uses to respond to now-inadequately met mission needs. Notable among these are expansion of the confined area for the JIC and creation of additional quiet areas for focused preparation of briefings and reports.

d. The OPHPR Director should address the issues of noise by examining the feasibility of implementing the previously developed sound deadening plan for the EOC main room.

9. CDC Buildings and Facilities operations should address the HVAC Environment: Identify and implement improvements to the heating, ventilation, and air conditioning throughout the EOC.

10. Virtual Emergency Management: Develop a plan to maximize the use of virtual coordination, collaboration, decision-making, and administration for the array of CDC emergency management approaches from short-duration, limited-scale incidents to extended, enterprise-level incidents. CDC’s management of emergencies in many instances is an enterprise endeavor in which the EOC itself is but one component. CDC’s capacity, agility, and effectiveness in emergency management would likely be enhanced through application of existing, proven virtual systems. Most significant is the potential to speed and improve the insight and quality of collaborative decision making by virtual means that engage stakeholders across CDC as needed. A collateral benefit should be reducing the need for SMEs to relocate physically to the EOC for an incident. Achievement of effective virtual collaboration and decision making should increase the

number of incidents that are addressed effectively by CDC short of activating the EOC. Commonly cited inhibiting factors in use of the EOC, such as tracking of personnel and their relevant capabilities can be reduced by other complementary IT-based systems. These actions may also result in improved emergency management outcomes, a higher level of CDC participant satisfaction, and lower financial cost to CDC.

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11. Explore the value/cost savings/issues of virtual capabilities (coordination, collaboration) for present EOC (Atlanta). Explore the value/cost savings/issues of satellite EOCs for places not on Clifton Road (e.g., Chamblee or Fort Collins). This will be addressed via a cost benefit analysis.

12. The CDC senior leadership needs to engage appropriate facilities management components of CDC to develop and implement plans to address:

- o Parking: Consideration should be given to blocking a group of parking spaces reserved for personnel deployed to the EOC during an activation or other emergency response, especially for those not usually located on the Roybal Campus.
- o Food Service: Reliable solutions are needed for 24-hour food service during an activation to include healthy and nutritious food options
- o Hygiene and rest: Options should be developed and implemented to assure adequate access to shower, bathroom, and rest areas during an activation.

Discussion:

None

Motion and vote to approve: recommendations (5-12)

S. Hoffman: Yes
E. MacKenzie: Yes
J. Muckstadt: Yes
L. Rowitz: Yes
R. Ursano: Yes
L. Kaplowitz: Yes
M. Butel: Yes
S. Phillips: Yes

B. Ellis: We have six more focus areas and I can just ask voting members if there are any of the six that you would like to have more discussion on. If there are no questions, I will move to vote on 13 through 48, but I was made aware that there were some questions around Recommendations 46-48.

S. Hoffman: I was confused by the discussion on 46-48.

B. Ellis: Any others? If we vote on 13 through 45 and then stop and talk about 46-48, would that be acceptable? So the next motion is to approve recommendations 13-45 and table 46-48 for our August meeting.

Focus Areas: EOC procedures and services, feedback mechanisms, training, metrics, and Director's Critical Information Requirements (DCIR); Recommendations (13- 45)

13. A "human resources" activity should be built into the EOC. Such an activity would help orient personnel as they come into the EOC, and could include the "concierge" function

mentioned above. The HR function would also have responsibility for keeping formal rosters of available staff for any response. At present, the rostering function appears relatively ad hoc. The HR component would also be responsible for debriefing personnel when they finish their tour of duty in the EOC.

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14. There needs to be more structured procedures for deactivation of a response. In NIMS, deactivation is a responsibility for the planning section and begins almost immediately. However, since many CDC activations use a modified NIMS structure, deactivation may not be as formalized. It appears that most responses simply “run out of steam” rather than end through systematic planning. This is important for those involved in the response, because otherwise the activity appears needlessly open-ended.

15. Every individual who takes part in a response needs to have clear time frames for the duration of their involvement (i.e., a set tour of duty). Too often the duration of an assignment is unclear or is extended, and this uncertainty decreases the level of enthusiasm to take part in emergency responses. The analogy is uncertain deployments or repeated deployments in the military and the effect this has had on morale.

16. The EOC needs to systematically evaluate which functions need to be physically present in the EOC and which can be done remotely. There is no need to use seats in the EOC for groups that are needed sporadically or for minimal periods of time. This results in either empty desks or individuals who are sitting around doing their normal work from the EOC. This wastes space and resources.

17. Because events that do not reach the level of EOC involvement may be worked outside the EOC at program levels, it is important to develop a standard and centralized process for programs to inform the EOC of events being worked outside of the EOC to ensure communication flow is both out of and into the EOC.

18. A task force should review resources and capabilities (IT tools) for sustaining EOC situational awareness capabilities (e.g., data mining, visualization). This is a rapidly growing area that will require ongoing development and review to stay current and be most useful to the EOC.

19. The DEO should examine the possible benefits to EOC and program coordination of social networking as a component of building collaborative operations with programs.

20. As stated above, the DEO should develop and maintain virtual networks to expand the CDC’s linkages among campuses and with external stakeholders.

21. In-progress action reports. For prolonged activations, there should be periodic “in-progress” reviews to make sure course changes and corrective actions can be taken during the response rather than waiting until it has ended. This would be a periodic “pulse check” to identify problems and issues. It is suggested that an in-progress review be done monthly for prolonged responses.

22. All persons engaged in a response should be debriefed at the time their tour of duty ends (see also recommendation 16 above). This debriefing can be done face-to-face, or could be a web-based survey that is completed as part of out-processing. It allows everyone to contribute to feedback, especially when the experience is freshest in their mind.

23. The stakeholder survey conducted in the fall of 2009 should be repeated on a periodic basis and trends in satisfaction should be measured. As a suggestion, the survey (or a simplified version of it) should be done annually. Results should be distributed.

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24. AARs play an important role in an EOC. It is recommended that a specific, separate review be undertaken for the AAR to identify any corrective actions necessary to ensure that AARs are having their intended impact.

25. An external customer survey should also be accomplished. This would include stakeholders such as states, Federal departments, international partners, NGOs, and private sector partners.

26. Consideration should be given to establishing a standing technical advisory group of SMEs from the CDC organizational components most likely to use the EOC. Note that this is specifically SMEs not only those engaged in the emergency operation but individuals who can contribute knowledge of how their subject area operates in the field to enhance SME-EOC collaboration and knowledge from SMEs to EOC (see also recommendation 2).

27. A suggestion box in the EOC for users (provide confidential feedback mechanism).

28. CDC should identify those individuals likely to lead or play a major function in emergency response or EOC activation. Such individuals should be fully certified in NIMS and such certification should be documented. Mandatory NIMS training is required for personnel in accordance with the tier system already in place.

29. An EOC training video would be helpful, not only for internal stakeholders but also for external stakeholders. This video (or videos) may address increasing knowledge about the EOC, marketing of the EOC and orientation for new personnel. Such a video will require good production qualities to be useful. Such a product may also help to reduce the large number of tours currently given of the EOC. This is distracting to personnel working there and also consumes valuable staff time.

30. A cross-training plan should be developed for EOC staff and responders. It is recognized that the bench strength may not be deep in a number of areas. If illness occurs or positions are vacant, there may be insufficient personnel with the depth of knowledge necessary for 24-hour coverage of a position or activity. Maximizing cross-training within EOC sections can facilitate increased ability to surge and enhance information sharing. Familiarization and liaison activities across functions in the EOC will also facilitate and increase understanding, team function, information sharing and participation.

31. It is important to continue the operational plan for which prolonged activations employ rotating incident commanders. This also assists in training a cadre of personnel with the necessary skills.

32. Training for operating in the EOC should be developed to match the job and responsibilities of the individuals involved and not only be general or command structure only knowledge.

33. Personnel training policies should be reviewed to ensure that appropriate career training or mentoring is available and used to develop these skilled individuals. More generally, leadership and management skills may be increasingly necessary for CDC personnel to

address the response capabilities for the agency.

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34. EOC training and service across CDC should be incentivized using formal and informal policy (e.g., awards, recognition). Training requirements should be part of the personnel position descriptions and evaluation process. Position descriptions should include roles expected to be performed in the incident management system. A job category for emergency management personnel across levels of skill and seniority is needed.

35. Conduct an in-depth analysis of several activations/responses to measure the potential impact and cost savings that accrued from operating within the EOC/emergency response framework. The methodology for such an evaluation should be worked out with an objective external party(s).

36. Periodically repeat the stakeholder survey done in the fall of 2009 to measure trends in satisfaction, knowledge, and attitudes regarding the EOC (see recommendation 26 above).

37. As in recommendation 15 above, operationally debriefing will also provide important metrics. The workgroup recommends debriefing EOC users at the end of their tour of duty and measuring their satisfaction with their deployment to the EOC.

38. Measure utilization of the EOC by organizational entity, type of response, number of responders, and duration.

39. DCIRs are one communication tool. There are others which are also highly valued for providing information vertically and horizontally. It is important to identify and prioritize all communication tools that enable both leadership and operators to stay informed.

40. The CDC Director's Office and Centers should identify essential elements of information and tools to inform the EOC of information they believe is most important to EOC and CDC-wide emergency operations.

41. Create a DCIR review/creation process if it has not already been done.

42. DCIRs should be refined in an ongoing manner to reflect the critical information that should be reported to the Director and when the director should be called to alert of an event.

43. DCIRs should be carefully constructed to reflect specific needs and events and named for each event.

44. When DCIRs are modified they should also have a dissemination plan and a plan for when they will be reviewed.

45. The DCIR development process should be created with input from the SMEs staffing the EOC.

Discussion:

No discussion

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Motion and vote to approve: recommendations (15-45)

S. Hoffman: Yes
E. MacKenzie: Yes
J. Muckstadt: Yes
L. Rowitz: Yes
R. Ursano: Yes
L. Kaplowitz: Yes
M. Butel: Yes
S. Phillips: Yes

B. Ellis: So I'm going to turn the discussion over to Lou for further discussion on recommendations 46-48

L. Rowitz: Any questions on recommendation 47? [No response noted]. What about recommendation 48? [No response noted].

R. Ursano: I think most questions were on recommendation 46. What about changing the wording to "creating a planning cycle"? Does that word change capture it?

L. Rowitz: So Bob's suggestion is to drop five-year and just have it as create a planning cycle.

D. Sosin: One area where there was some confusion is on the scale of the planning effort and whether the CDC should be taking on a larger planning effort. There were some concerns in OPHPR about the feasibility of doing that.

L. Rowitz: How about tabling recommendations 46 to 48 to the next BSC meeting and not voting on those at this meeting?

R. Ursano: I think that would allow us to get some more information and understanding from OPHPR on what might be helpful.

S. Hoffman: Is the BSC able to tell the CDC Director to do things or just OPHPR?

B. Ellis: The BSC charter specifies that you are able to make those recommendations.

So let's vote. Are we going to table recommendations 46 through 48 to further discuss at the August meeting?

Motion and vote: To table recommendations (46-48) until August 2011 meeting

S. Hoffman: Yes
E. MacKenzie: Yes
J. Muckstadt: Yes
L. Rowitz: Yes
R. Ursano: Yes
L. Kaplowitz: Yes
M. Butel: Yes
S. Phillips: Yes

Association of Public Health Laboratories (APHL)

No updates provided.

Association of Schools of Public Health (ASPH)

No updates provided.

Association of State and Territorial Health Officials (ASTHO)

Dr. Damon Arnold attended an ASTHO meeting that also included representatives from CDC and HHS on April 20-21, 2011 in South Carolina. The meeting was regarding the new funding opportunity announcement (FOA), emergency funds, and how they will affect ASTHO operations. ASTHO is still pushing forward and making sure that these activities are fully funded.

With respect to surveillance work around the incident in Japan, there is work currently taking place. ASTHO is working with CDC on areas that are a concern to the Board. He thanked CDC for their hard work in helping to craft ASTHO's document. He also praised CDC for their support to the states in spite of fiscal constraints. ASTHO feels very much supported by CDC.

Council of State and Territorial Epidemiologists (CSTE)

Dr. Patricia Quinlisk echoed Dr. Arnold's sentiments and noted a great response from the CDC EOC. She noted her appreciation for the work on these recommendations. Her only update is that CSTE has an upcoming national meeting.

National Association of County & City Health Officials (NACCHO)

Dr. Karen Smith complemented the BSC on a well-crafted document. She said that everyone is acutely aware of the budget issues. In many places what is disproportionately being affected are STD and communicable disease infrastructures. These are supported by state and local level agencies. The economy is affecting those local and county governments, so it is making an impact on the infrastructure. She also extended thanks to Division of State and Local Readiness and recognized the outreach efforts by OPHPR for carefully crafting thoughtful guidance for the Public Health Emergency Preparedness cooperative agreement. We lost 19% of local public workforce last year. Communicable disease infrastructure is affected as it is supported by Federal funding. The ramifications of the economy are having an impact on the local. We appreciate the outreach from OPHPR to locals in operationalizing a framework.

National Indian Health Board (NIHB)

No updates provided, NIHB representative not in attendance.

M. Gilchrist: Is OPHPR or CDC going to issue a response to the Inspector General on the lack of outreach for state and local laboratories. We have some ideas for ways to improve upon that that we think would be helpful.

B. Ellis: I will follow up with you on that. I'll just open the floor one last time for comments or questions. [No further questions or comments were noted]

L. Rowitz: I want to thank Bob for helping me co-chair on this group.

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R. Ursano: I want to thank Barbara, her office, and OPHPR for their hard work.

B. Ellis: I am absolutely amazed at the work the group did today. Thank you all for the incredible work, and thank you to Lou for coming in person. You and Bob

have done the lion's share of the work. We will revisit the three final recommendations, 46-48, at the next BSC meeting in August.

J. Muckstadt: Any idea of when in August?

B. Ellis: No, not as of yet, but we will reach out to you all to find time to meet in-person in Atlanta

ADJOURN-CERTIFICATION

With no further business raised or discussion posed, Barbara Ellis officially adjourned the BSC meeting.

I hereby certify that to the best of my knowledge, the foregoing minutes of the April 22, 2011 OPHPR BSC meeting are

accurate and complete:

Date: 07/18/2011

signed

Barbara A. Ellis, Ph.D., Designated Federal Official

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OPHPR BSC MEMBERSHIP ROSTER

Chair

Vacant

Executive Secretary

Barbara A. Ellis, Ph.D.

Associate Director for Science

Office of Public Health Preparedness and Response

Centers for Disease Control and Prevention

Board Members

Sharona Hoffman, J.D., L.L.M

Professor of Law and Bioethics

Case Western Reserve University School of Law

Cleveland, OH

Term: 2/6/2008 – 9/30/2012

Ellen MacKenzie, Ph.D.

Professor and Chair

Department of Health Policy and Management Johns Hopkins University

Bloomberg School of Public Health

Baltimore, MD

Term: 2/6/2008 – 9/30/2011

John (Jack) Muckstadt, Ph.D.

Professor

School of Operations Research and

Industrial Engineering - Cornell University

Ithaca, NY

Term: 2/5/2008 – 9/30/2011

Louis Rowitz, Ph.D.

Director
Mid-America Regional Public Health Leadership Institute - University of Illinois at Chicago,
School of Public Health
Chicago, IL
Term: 2/18/2008 – 9/30/2012

Robert J. Ursano, M.D.
Chairman, Department of Psychiatry
Uniformed Services University of Health Sciences
Bethesda, MD
Term: 6/25/08 – 9/30/2012

Ex Officio Members
RADM Nicole Lurie, M.D., M.S.P.H.
Assistant Secretary for Preparedness and Response
U.S. Department of Health & Human Services
Washington, DC

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Alexander Garza, M.D., M.P.H.
Assistant Secretary for Health Affairs and Chief Medical Officer
U.S. Department of Homeland Security
Washington, DC

COL Michael G. Butel, D.V.M., M.P.H.
Assistant Secretary of Defense (Health Affairs) Force Health Protection and Readiness;
Director, Global Health Surveillance
U.S. Department of Defense
Arlington, VA

Liaison Representatives
Association of Public Health Laboratories (APHL)
Mary J. Gilchrist, Ph.D., D(ABMM)
Consultant, Public Health
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Association of Schools of Public Health (ASPH)
James W. Curran, M.D., M.P.H.
Dean, Rollins School of Public Health
Co-Director, Emory Center for AIDS Research
Emory University
Atlanta, GA

Association of State and Territorial Health Officials (ASTHO)
Damon T. Arnold, M.D., M.P.H.
Director, Illinois Department of Public Health
Chicago, IL

Council of State and Territorial Epidemiologists (CSTE)
Patricia Quinlisk, M.D., M.P.H.
Medical Director and State Epidemiologist
Iowa Department of Public Health
Des Moines, IA

National Association of County and City Health Officials (NACCHO)
Karen Smith, M.D., M.P.H.
Public Health Officer and Director of Public Health
Napa County Health and Human Services Agency Public Health Division
Napa, CA

National Indian Health Board (NIHB)
Stacy A. Bohlen, M.A.
Executive Director, NIHB
Washington, DC?

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PARTICIPANT LIST

LAST NAME/FIRST NAME/AFFILIATION/ROLE/By PHONE

Arnold/Damon/Liaison-ASTHO/Yes
Boedigheimer/Steve/CDC OPHPR/No
Butel/Michael/Ex Officio - DOD/Yes
Cioffi/Joan/CDC OPHPR/No
Crawford/Clarissa/PSA/No
Curran/James/Liaison - ASPH/Yes
Davis/Xiaohong/CDC OPHPR/No
Ellis/Barbara/CDC OPHPR/No
Gardner/Demetria/CDC MASO/Yes
Geibe/Jesse/Alternate Ex Officio-DOD/Yes
Gilchrist/Mary/Liaison APHL/Yes
Hoffman/Sharona/BSC Member/Yes
Jennings/Matthew/CDC OPHPR/No
Kaplowitz/Lisa/Alternate Ex Officio-HHS/Yes
Khan/Ali/CDC OPHPR/No
Kokor/Valerie/CDC OPHPR/No
Logan/Marinda/CDC OPHPR/No
Love/Tangela/Peachtree Suite/No
Lurie/Nicole/Ex Officio-HHS/Yes
MacKenzie/Ellen/BSC Member/Yes
Muckstadt/Jack/BSC Member/Yes
Navin/Phil/CDC OPHPR/No
Phillips/Sally/Alternate Ex Officio-DHS/Yes
Quinlisk/Patricia/Liaison-CSTE/Yes
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Sanders/Lee/CDC OPHPR/No
Singleton/Christa/CDC OPHPR/No
Smith/Karen/Liaison-NACCHO/Yes
Sosin/Dan/CDC OPHPR/No
Ursano/Robert/BSC Member/Yes
Vaughn/William/Georgia State University/Yes
Weyant/Rob/CDC OPHPR/No
Wooster/Mark/CDC OPHPR/No

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ACRONYMS

AAR After Action Report/Review
ADS Associate Director for Science
APHL Association of Public Health Laboratories
ASPH Association of Schools of Public Health
ASPR Assistant Secretary for Preparedness and Response (HHS)
ASTHO Association of State and Territorial Health Officers
BSC Board of Scientific Counselors
CA Cooperative Agreement
CDC Centers for Disease Control and Prevention
COOP Continuity of Operations Plan or Continuation of Operation Plan
COTPER Coordinating Office for Terrorism Preparedness and Emergency Response (CDC)
CSTE Council of State and Territorial Epidemiologist
DCIR Director's Critical Information Requirements (CDC)
DEO Division of Emergency Operations (CDC)
DEOC Director's Emergency Operation Center (CDC)
DFO Designated Federal Official
DHS U.S. Department of Homeland Security
DHHS U.S. Department of Health and Human Services
DOD Department of Defense (also DoD)
DSLIR Division of State and Local Readiness (CDC)
EOC Emergency Operations Center (CDC)
FACA Federal Advisory Committee Act
FOA Funding Opportunity Announcement
FOIA Freedom of Information Act
FRN Federal Register Notice
HHS Health and Human Services
HR Human Resources
HVAC Heating, Ventilation, and Air Conditioning
ICS Incident Command System
IG Inspector General
IMS Incident Management System
IOM Institute of Medicine
IRCT Incident Response Coordination Team
IT Information Technology
JIC Joint Information Center
MASO Management Analysis and Services Office (CDC)
NACCHO National Association of County and City Health Officials
NIHB National Indian Health Board
NIMS National Incident Management System
NIOSH National Institute for Occupational Safety and Health
OD Office of the Director
OPHPR Office of Public Health Preparedness and Response (CDC)
PAHPA Pandemic and All-Hazards Preparedness Act (PL 109-417)
SGE Special Government Employee
SME Subject Matter Expert
USPHS United States Public Health Service