Meeting of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health

Federal Trade Commission Satellite Building and Conference Center
601 New Jersey Avenue NW
Washington, DC

First Meeting: April 12-13, 2011

ATTENDEES

Advisory Group Members:

Jeffrey Levi (Chair), JudyAnn Bigby, Valerie Brown, Jonathan Fielding, Ned Helms, Patrik Johansson, Charlotte Kerr, Elizabeth Mayer-Davis, Vivek Murthy, Barbara Otto, Linda Rosenstock, John Seffrin, Ellen Semonoff, Susan Swider, Sharon Van Horn

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

Jack Stein (Office of National Drug Control Policy), Mary Engle (Federal Trade Commission), Michelle Sternthal (Department of Housing and Urban Development), Don Yu (Department of Education), Heather Raeburn (Department of Labor), Rachel Thornton (Department of Housing and Urban Development), Andrew Rein (Department of Health and Human Services), Kathi Grasso (Department of Justice) and Jack Smith (Department of Defense).

HHS Staff:

Regina Benjamin, Corinne Graffunder, Mary Beth Bigley, Catherine McMahon, Brigette Ulin, Damon Thompson, Lauren Gase, Olga Nelson

ACTION ITEMS AND NEXT STEPS

CDC/OSG:

- Identify areas in the National Prevention Strategy that require additional input.
- Once approved by the Office of Health Reform, send talking points on the National Prevention Strategy to members of the Advisory Group.
- Schedule a web-based meeting for the Advisory Group to continue its work on recommendations for changes and/or additions to the National Prevention Strategy.
- Present the recommendations to the full National Prevention Council, and to all 17 participating federal departments, either on behalf of the Advisory Group or with members present.

Advisory Group:

- Form working groups to address the gaps identified by CDC and OSG.
- Form a working group to craft messages that can be used to communicate about the National Prevention Strategy with constituents.
- Form a working group that will provide guidance on implementation with stakeholders and other entities from outside of the public health sector.
- Form an integrated partnership to facilitate a dialogue with stakeholders and encourage creative thinking.
- Send to Dr. Graffunder contact information (email, phone) to be shared with Advisory Group members.
- Create any additional working groups necessary to address areas that need further support.

I. WELCOME BY CHAIRPERSON AND DR. BENJAMIN 1:00 P.M.– 1:20 P.M.

Dr. Jeffrey Levi, chair of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (hereinafter called the Advisory Group) and Executive Director of Trust for America's Health, welcomed participants to the first meeting of the Advisory Group. He noted that the formation of the Advisory Group and its federal counterpart—the National Prevention, Health Promotion, and Public Health Council (hereinafter called the National Prevention Council)—represent a historic moment in our nation's approach to health and well-being. Created under the Affordable Care Act (ACA), the structure of the National Prevention Council demonstrates that prevention and wellness are the responsibilities of all government agencies-not just those with missions that are specific to health. He emphasized that factors that most contribute to health may be outside the health care system, such as jobs, education, housing, and community access.

Dr. Levi introduced Dr. Corinne Graffunder, the Designated Federal Officer (DFO) for the Advisory Group, who took the roll call. He then introduced Vice Admiral Regina Benjamin, United States Surgeon General and chair of the National Prevention Council. Dr. Benjamin welcomed the newly appointed members, and noted the opportunity to bring prevention to the forefront. She explained that the Office of the Surgeon General (OSG) had been working on the National Prevention and Health Promotion Strategy (hereinafter called the National Prevention Strategy) for some time. She noted that public comment on a draft framework had previously been collected. Originally the National Prevention Strategy was due to be presented to Congress on March 23, 2011, but the National Prevention Council believed it was important to gather this Advisory Group's input before presenting the final version of the National Prevention Strategy to Congress and the President.

Dr. Benjamin thanked the 17 federal agencies that have been participating in the National Prevention Council. She also acknowledged the National Prevention Council designees who were present at the meeting (see list on page 1 of this summary). The National Prevention Council, established by the President in June of 2010, has been working to identify the most effective and achievable means of improving the nation's health through an increased focus on prevention and health promotion in all federal policies and programs. It is also responsible for coordinating prevention, wellness and health promotion efforts across the federal government and ultimately across the nation. The National Prevention Council is required to submit the National Prevention Strategy to Congress, and to also submit an annual report to Congress.

Dr. Benjamin explained that the Advisory Group had been appointed by the President in January of 2011 to provide input to the National Prevention Council. The Advisory Group comprises up to 25 non-federal employees with diverse backgrounds and training. Of these, 15 members have been appointed to-date. The Advisory Group is being administered by the Department of Health and Human Services (HHS) and will report to OSG. Dr. Benjamin noted that as a family physician, she saw missed opportunities for prevention in health care settings around the nation and that if we really want to change the way we think about health in this country, it calls for our nation to take a more holistic approach to community health. Dr. Benjamin thanked the Centers for Disease Control and Prevention (CDC) for providing staff to work on the National Prevention Strategy. She also thanked the 17 federal agencies for their work on the National Prevention Strategy and emphasized that all efforts to produce the final document will be as collaborative as possible.

II. OPENING STATEMENTS BY ADVISORY GROUP MEMBERS 1:20 P.M.– 2:15 P.M.

Dr. Levi welcomed the Advisory Group members and invited each member to share information about their background and expectations. The members made brief statements about their training and experiences and what they hope to accomplish through their work on the National Prevention Strategy. Examples included:

- Reinforce the notion that every sector has a role to play in creating health, create a model for how states and other entities can translate that concept into action, and move away from categorical funding for solutions;
- Get back to basics in health care and prevention (e.g., breastfeeding, nutrition, portion control, dental care, emotional well-being, physical activity, minimizing environmental exposures);
- Empower individuals and communities to take control of their health; shape the ways the non-health sides of government address prevention;
- Cultivate an integrated health care system with prevention and health promotion as its centerpiece;
- Emphasize the role of evidence; incentivize systems for prevention; value the whole person and focus on wellness;
- Promote interdisciplinary collaboration, and ensure that there are equal, "win-win" benefits for agencies that are represented in interdisciplinary prevention effort—not just benefits for health;
- Local government is where big policy decisions actually come to the community and is the place for innovation and community data.
- Involve the private sector and address underlying determinants of health;
- Support a culture change in leadership that permeates the entire government and emphasizes prevention.

Dr. Levi added that he saw two accomplishments for the Advisory Group: (1) to keep people's attention focused on prevention; and (2) ensure culture change in how the entire federal government perceives health takes root. After the members gave their remarks, Dr. Benjamin emphasized that the National Prevention Strategy is intended to be a living document and that she expects it will change over time as health priorities shift and change.

III. OVERVIEW OF THE NATIONAL PREVENTION STRATEGY — 2:30 P.M. – 3:00 P.M.

After a break, Dr. Levi explained that the Advisory Group would hear background on the work that has been done on the National Prevention Strategy to-date; they would then briefly discuss the National Prevention Strategy before opening the floor for public comment. He introduced Corrine Graffunder, from the CDC's Office of the Associate Director for Policy, who has been providing staff support to the National Prevention Council for the development of the National Prevention Strategy. Dr. Graffunder began by explaining that the public conversation about the Affordable Care Act (ACA) often focuses on coverage, health care cost or quality, but it also includes important provisions for prevention. The work of the National Prevention Council and the National Prevention Strategy serves as a foundation for prevention within the Affordable Care Act.

The document is intended to be a living mechanism through which the National Prevention Council will provide federal leadership and prioritize important approaches, strategies, policies, and programs to address the nation's well-being and improve health status. Annual status reports on the progress of the National Prevention Strategy are required, reflecting a structural commitment to promoting ongoing responsibility and accountability. The National Prevention Council produced its first annual status report in 2010. This report laid the foundation for the National Prevention Council work going forward and for the development of the National Prevention Strategy. There have been conversations with other federal departments about how to work across the 17 federal agencies and to reach out and expand beyond those agencies.

The role of the Advisory Group is critical in this regard, as the federal government cannot accomplish the goals of the National Prevention Strategy without nongovernmental involvement. The Advisory Group is one built-in part of the infrastructure to assure public comment and engagement.

The National Prevention Strategy should be grounded in the evidence-base, and should seek to build the existing base of knowledge and evidence. Aligning and focusing federal resources is critical, as is coordination with other national efforts. The National Prevention Council has worked closely with the National Quality Strategy, the other strategy that was mandated through ACA.

In its capacity as the support office, the CDC interviewed representatives of every department participating in the National Prevention Council to gain input on prevention priorities. Many in-person meetings were held to devise cross-cutting, multisectoral recommendations; the effort represented a serious investment on the part of the 17 agencies. The National Prevention Council also sought two rounds of formal public input, and received hundreds of submissions. Additionally, individual departments have engaged their constituents, such as by presenting at conferences or holding stakeholder calls. Staff has been working to process and integrate that input in a cohesive way.

The framework that the National Prevention Council has been working through includes an overall vision and measurable goal, followed by a set of priorities that are supported by key evidence-based recommendations. Each priority area includes key indicators and actions that will be taken to drive progress. The vision and goal of the National Prevention Strategy are as follows:

- ***Vision***: *Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.*
- ***Goal***: *Increase the number of Americans who are healthy at age 85.**

Dr. Graffunder explained that the goal is part of an evolving process to have a National Prevention Strategy that Americans can relate to, but that is also scientifically valid and feasible.

The National Prevention Strategy is guided by four pillars: Healthy Communities, Preventive and Clinical Community Efforts, Empowered Individuals, and Elimination of Health Disparities. Elimination of Health Disparities was added to the pillars section in response to public comments emphasizing that this should be a priority area. The four pillars are being used to guide the content of every chapter of the National Prevention Strategy, and recommendations will address the pillars. The National Prevention Council is working to identify specific metrics for each of these pillars.

Dr. Graffunder presented the Priorities of the National Prevention Strategy; they are three cross-cutting priorities (i.e., healthy environments, prevention and public health capacity, and clinical preventive services), and seven targeted priority areas (i.e., Tobacco Free Living; Preventing Alcohol & Other Drug Abuse; Healthy Eating; Active Living; Injury Free Living; Mental and Emotional Wellbeing; Sexual Health). As a result of the public comment submissions "eliminate health disparities," became a pillar, and "sexual health" was included as a targeted priority area. Each chapter includes draft content and draft recommendations that have been devoted to each targeted priority areas. Each draft recommendation has a brief statement of evidence-based approaches. The 17 departments were asked to provide input on additional approaches and metrics, and based on their feedback the chapters were further developed.

Although they have not yet focused extensively on implementation, members have agreed to begin working together as the National Prevention Council to identify specific steps that each department and stakeholders can take, individually and collectively, to advance an action-oriented process. There are roles for federal implementation that are required by statute, including an ongoing process for public input and a need to establish measurable actions and monitoring. The National Prevention Council has discussed ways to think of implementation beyond what is statutorily required, including how organizations, agencies, communities, and state and local governments can align with each other and with the targeted priority areas and recommendations. The National Prevention Council has also examined ways to engage partners across the federal government, public and private sectors, and non-governmental agencies. The National Prevention Council will continue to build analysis, evaluation, and accountability into the process.

Dr. Graffunder referred to a webpage on the healthcare.gov website that provides information about the National Prevention Council: http://www.healthcare.gov/center/councils/nphpphc/. The site provides an email address where the public can submit comments. It was considered important that the Advisory Group provide input prior to the release of the National Prevention Strategy, therefore the Advisory Group's recommendations would be taken back to the designees of the National Prevention Council prior to the start of a clearance process. At this point in time, a late spring release is anticipated..

IV. DISCUSSION OF THE NATIONAL PREVENTION STRATEGY 3:30 P.M.-4:00 P.M.

Dr. Levi asked if there were questions before they turned to the overview of the draft framework of National Prevention Strategy. Sister Kerr asked how many participants had attended Dr. Benjamin's calls with the public. (Four or five calls were held to publicly vet the draft framework of the National Prevention Strategy; about 1,500 people joined the call with the most participants.) Ms. Brown asked what criteria were used to select evidence-based practices for inclusion. Dr. Graffunder explained that evidence-based practices had been cross-walked with the U.S. Preventive Services Task Force Clinical Guide, the Community Guide, and IOM recommendations.

Vision and Goal of the National Prevention Strategy

Dr. Levi led the group in a discussion of **the vision** of the National Prevention Strategy, "*Working together to improve the quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness*" and **the goal** of the National Prevention Strategy, "*Increase the number of Americans who are healthy at age 85*". Dr. Benjamin said the goal implies that the National Prevention Strategy will seek to increase the life expectancy of the U.S. population. Dr. Rosenstock, said the vision and the goal should clarify that the National Prevention Strategy aims to increase the number of Americans who are healthy at all ages, and then there can be specific measureable objectives, including increasing the number of people who are healthy at 85. Dr. Mayer-Davis suggested using the phrase healthy at age one and healthy at age 85. Dr. Fielding suggested that the broader goal not be quantified and then have quantification underneath associated with different stages of life. He elaborated that an increase in the percentage of people who are healthy at 85 does not mean that many young children won't have serious health conditions. Both he and Dr. Murthy suggested providing a definition of the term "healthy," which can be a subjective concept. Additionally, Dr. Fielding cautioned against using language that prompts a focus on individuals; he suggested rewording to include macro-level determinants of health, including culture and environment.

Dr. Bigby encouraged reconsideration of language that refers to "moving from disease prevention to wellness promotion" because people want to be assured that when they are sick they will receive quality care. Dr. Murthy suggested being explicit about how broadly engagement for the National Prevention Strategy will be – for example,

will it include members of the public, nonprofit groups and businesses or just the federal government. Dr. Benjamin and Dr. Graffunder clarified that the National Prevention Strategy will include recommendations that the federal government will do and recommendations that partners can do. Additionally, Dr. Murthy, following up on Dr. Bigby's point, stated that the concept of "culture change" of prevention be incorporated into the mission so as to move away from an either or of sickness or wellness.

Dr. Seffrin said the framework should reduce the number of people who are disabled by age 85 – keeping people healthy, independent, and free of pain. Mr. Helms suggested that we focus instead on creating the conditions for the healthiest population possible, rather than preventing disease and disability. In doing so, we'll be able to engage other actors that are not traditionally part of prevention, as is reflected on the National Prevention Council.

The "Pillars" of the National Prevention Strategy

The group proceeded to discuss the pillars of the National Prevention Strategy. *Healthy Communities, Preventive Clinical and Community Efforts, Empowered Individuals, and Eliminating Health Disparities*. Ms. Brown asked that underserved populations be explicitly mentioned. Dr. Mayer-Davis said integration and cohesiveness among the pillars is missing. Ms. Semenoff inquired about the relationship between the pillars and priority areas. Dr. Graffunder explained that the pillars are general statements that provide a context for the entire National Prevention Strategy and they demonstrate how things relate to one another. The priorities will include recommendations for how to address certain health topics.

In reference to the "**healthy communities**" pillar, Dr. Fielding encouraged the National Prevention Council to include the social and physical environments as critical determinants of health and emphasize the conditions in which people can be healthy. Dr. Levi said the healthy community pillar and healthy environment priority overlap.

In reference to the "**preventive clinical and community efforts"** pillar, Dr. Rosenstock suggested that the pillar should be community preventive efforts with a cross-cutting theme of clinical preventive services.

In reference to the "**empowered individuals**" pillar, Dr. Fielding said this framework places emphasis on the individual, but it is important to be responsive to decision making that occurs at the group level. Dr. Levi felt this section was focused on providing information to individuals but needed to also recognize that we, specifically the federal government, should create the environment for individuals to become empowered.

In reference to the "**eliminating health disparities**" pillar, Dr. Levi encouraged the National Prevention Council to consider using "health equity" because it is aspirational and positive and different from eliminating health disparities.

Priorities

Dr. Levi led discussion of the cross-cutting and targeted priorities of the National Prevention Strategy. In reference to the layout of the priorities, Dr. Graffunder explained each priority area includes a set of recommendations; and will eventually include a set of statements underneath for evidence-based actionable items. Dr. Levi commented that some of the recommendations are more likely guiding principles than actionable recommendations. He advised CDC and OSG to review which are really recommendations or guiding principles.

Dr. Fielding suggested that the **"sexual health"** target priority should be renamed "Reproductive and Sexual Health," a more comprehensive title.

Regarding the cross-cutting priority, "**healthy environments,"** Dr. Rosenstock approved of the description, but would like to see a reference to the nonphysical and non-biological exposures that affect health such as the

psychosocial factors. Dr. Murthy suggested adding a reference to how we dialogue about health as one of the nonphysical factors that can affect health. Ms. Brown also stressed that action at the local and community level is critical and needs to be included not only in the actions but in the contextual language.

Regarding the cross-cutting priority, "**prevention and public health capacity**," Dr. Fielding felt that building the evidence base was missing and would like to see the inclusion of incentives. Dr. Levi said there is a need to define "public health infrastructure" more clearly, and to be more explicit in recommendations around preparedness and community resilience. Dr. Benjamin reminded the group that HHS is not the only agency that proposed the recommendations in this area. Ms. Brown noted that an effort must be made to integrate data systems across sectors to ensure that the data presented are valued for policy decisions. Dr. Bigby suggested addressing the issue of resources including cost-saving benefit on medical services that are brought about by investing in public health and available resources when the uninsured become insured.

In reference to the "**clinical preventive services priority**," Dr. Mayer-Davis and Dr. Fielding cautioned on using specific examples of clinical services as it will appear those not listed are not important. Additionally, Dr. Fielding commented that counseling services were not mentioned. Mr. Helms suggested emphasizing the importance of delivering comprehensive clinical care, especially in the context of the medical home. Sister Kerr and Dr. Murthy added that there are health workers in the field who are employing innovative methods and practices to promote health. The National Prevention Council may wish to consider harnessing these innovations and establishing a vehicle for sharing practices with others in the field. Dr. Swider suggested expanding language on creating linkages between the health providers and the community preventive efforts occurring on the ground.

Dr. Van Horn suggested incorporating Sister Kerr's emphasis on healthy relationships into the "**mental and emotional well-being**" priority area.

In reference to the "**tobacco-free living**" priority area, Dr. Fielding stated that evidence-based prevention evidence-based practices were missing from this section. Dr. Van Horn recommended adding COPD and asthma to the list of diseases associated with tobacco use. Dr. Bigby suggested explicitly mentioning the populations that are vulnerable to tobacco use and perhaps include prevention strategies geared to address them. In particular Ms. Semonoff and Ms. Brown mentioned youth and using the education system to teach healthy choices. Ms. Otto reiterated an earlier point about including incentives, particular for local policy decision. For example, casinos may be exempted from smoke-free laws because they are a revenue generator but there may be ways to incentivize including casinos in smoke-free laws. Sister Kerr said messaging around tobacco needs to include interventions to teach individuals to get in touch with their bodies so they can experience the immediate benefits of not smoking. Dr. Levi commented on the need for the federal government to review its own policies around tobacco, particularly those affecting the military and veterans.

Dr. Levi thanked the members for their suggestions and explained that they would continue to discuss the National Prevention Strategy at the next day's meeting. He then opened the floor for public comment.

V. PUBLIC COMMENT PERIOD — 4:15 P.M.-5:30 P.M.

The table below outlines the comments received from the public.

Speaker	Organization	Summary of Comment
Ronald	American College of	ACOEM suggested that a fifth pillar of "healthy workplaces" be added alongside healthy

Speaker	Organization	Summary of Comment
Loeppke	Occupational and Environmental Medicine	communities. With more than 130 million workers spending the majority of their adult lives on the job, the sheer volume of individuals who can be reached at the workplace is vast. The workplace offers unique advantages and infrastructure to address health problems of the population. There is compelling evidence that shows that worker health and worker productivity are inextricably linked. Thus, the total cost impact of poor health for employers actually extends beyond just the medical pharmacy costs. Good health in the workplace will help build our nation's productive capacity at a time when it is critical to be globally competitive. The suggested four steps that they believe are essential: (1) The employer community must more aggressively embrace worksite wellness in an effort to create a new culture of health promotion as well as health protection for their employees. (2) Incentives at the federal, state and local levels should be adjusted and implemented encouraging employers to adopt effective wellness strategies. (3) We must develop a set of best practices of the evidence base for preventive medicine and health promotion that provides a roadmap for employers and use functional outcomes in addition to clinical and financial outcomes when mounting that evidence. (4) And an effort should be made to coordinate a strategy that includes linking the employer community with patient-centered medical home accountable cares organizations and the value-based benefit design.
Kimberly Beer	Arthritis Foundation	The Arthritis Foundation aims to reduce by 20 percent the number of people who are physically limited by arthritis. They are concerned that prevention efforts often focus only on chronic diseases such as heart disease, diabetes, or cancer – and fail to include the critical role that arthritis plays as a comorbidity. They believe that one cannot address chronic disease prevention without first addressing arthritis, which is a disease that affects over 50 percent of those with diabetes and heart disease compared to 20 percent of the population. The Arthritis Foundation believes it is important to limit the burden and impact of arthritis on our nation by including it as a chronic disease in our prevention initiatives moving forward. They suggest the nation more widely implement evidence-based strategies to fight arthritis, as it costs the U.S. economy a staggering $128 billion a year and it's the leading diagnosis for joint replacement and one of the fastest growing expenditures in the Medicare program. The National Public Health Agenda that was initiated by the Arthritis Foundation, the CDC, and 35 other organizations calls for a wider dissemination of four evidence-based strategies for the prevention of osteoarthritis. Physical activity, self-management, injury prevention and weight management are four proven evidence-based interventions that can curtail the osteoarthritis trajectory that is disabling more and more Americans each year.
Rachel Fahey	National Campaign to Prevent Teen and Unplanned Pregnancy	The National Campaign to Prevent Teen and Unplanned Pregnancy appreciates that sexual health is a targeted priority in the Strategy, and that it specifically mentions teen pregnancy and unplanned pregnancy prevention and the importance of effective sex education for youth. Ms. Fahey spoke about the critical health disparities that exist regard teen pregnancy and the associated socioeconomic factors to consider including school completion, a stronger workforce, healthier families, and stronger children and families.
Thomas Spangler	American Dental Association	The American Dental Association has devised ten specific recommendations for improving the oral health of Americans. They are: (1) Increased resources for the Division of Oral Health at CDC to enhance community water fluoridation. (2) Expand school-based dental sealant programs. (3) Encourage dental insurance plans to reward individuals for seeking preventive dental care. (4) Engage the private sector. (5) Strengthen dental public health infrastructures. (6) Establish nutritional standards for children in daycare, Head Start programs, as that also affects oral health care. (7) Make oral health education part of the school's curriculum. (8) Encourage coverage, tobacco cessation counseling, and reduction of the legal tobacco products. (9) Issue guidance including the use of mouth guards for athletes. (10) Promote advanced training for geriatrics for dentists.
Dolph	National Kidney	Chronic kidney disease is an under recognized and under treated public health problem in

Speaker	Organization	Summary of Comment
Chianchaino	Foundation	the United States, affecting an estimated 26 million adult Americans. It is largely asymptomatic in its early stages and therefore laboratory testing is necessary in order to detect chronic kidney disease early. There is also a gap in the knowledge on the relationship between chronic kidney disease and other chronic diseases including diabetes, hypertension, obesity, and cardiovascular disease. By improving our nation's chronic kidney disease detection, it will support the National Quality Strategy's focus on improving cardiovascular care. In conclusion, early detection of chronic kidney disease, diabetes, and hypertension should be a part of the comprehensive public health strategy to reduce the burden of chronic kidney disease and provide individuals with the information they need to make good health choices.
Anne De Biasi	Nemours	Nemours is a private foundation that operates a child health system. They thanked the council for recognizing private partners as being important to the common cause. As the Council is finalizing the strategy, it is important to continue to give attention to life span, and focus on important points on health trajectory. In addition, Nemours encourages a focus on early child development and to look at all the settings where children live, learn, and play. They appreciate the attention given to policies, systems, environmental program and practice change. However, practice change is critical and policy change can't occur without practice change, so it is important to give practitioners the tools, the resources, the technical assistance and the onsite training that they need to make the broader policy changes in practice. They also advise for greater alignment between the prevention efforts that are also going on at the Center for Medicare and Medicaid Services and at the various public health agencies. They believe there is a major opportunity to link prevention programs with the CMMI to promote innovative, integrated approaches to population-based prevention that addresses all the social determinants of health. The prevention strategy could serve as a vehicle for creating greater synergy between these different types of initiatives, especially the place-based initiatives, those that are looking to make change in communities. Communities should be able to apply for various different grants from different agencies and different departments.
Donna Feely	John Hopkins University	She would like to see more emphasis on integration, not just cross interagency collaboration on common goals, but also on the inclusion of integrative healthcare practitioners beyond the allopathic arena as a way to achieve some of the strategies. Also recommends that the Council work to create partnerships and memoranda of understanding with national nonprofit organizations in order to implement the Strategy.
Matt Myers	Campaign for Tobacco Free Kids	Tobacco is still the number one preventable cause of premature death and disease in this country. We know what to do to end the epidemic and the solutions are not expensive - however, we need to just focus on the issue of tobacco use. There are several good plans to reduce tobacco use, including the National Tobacco Control Action Plan and the CDC's Best Practices. In addition, the ACA provides the opportunity to expand cessation coverage for tobacco use to cover everybody on Medicaid and to complete the work with regard to Medicare. The framework is moving in the right direction but the Council should go further and be more specific, utilizing the tools and plans that have been already implemented to ensure this issue will be resolved.
Janet Kahn	Integrated Health Care Policy Consortium	The Integrated Healthcare Policy Consortium submitted a report to OSG regarding their recommendations on healthcare priorities that the nation should focus on, and they would like to share the document with the Advisory Council. In addition, they encouraged the Advisory Group to consider the full definition of the National Healthcare Workforce, which includes licensed, complementary and alternative medicine providers and integrative healthcare practitioners, when thinking about access issues and primary care shortages.

Speaker	Organization	Summary of Comment
Edward Grandi	American Sleep Apnea Association	The Advisory Group should factor sleep health into the Strategy, which has been shown to have a significant impact on the health of individuals. Specifically sleep deprivation can cause metabolic imbalance and excessive daytime sleepiness, which will lead to unhealthy eating habits and making modest exercise impossible. Sleep could impact the pillars as well as the priorities.
Peter Seguin	Uniformed Services University representing the American College of Preventive Medicine	Preventive medicine physicians are working on disease prevention and health promotion, and they should be utilized when working to implement national strategies to improve the nation's focus on prevention. Prevention medicine physicians would be able to facilitate the work of this group, and he urged the Advisory Group to think about them while finalizing the recommendations, specifically to the extent that preventive medicine physicians could be included on the recommendations on page five in terms of public health capacity. In addition, there is a discrepancy in the paragraph on the bottom of page five, as the paragraph focuses on emergency preparedness and respond, and the recommendations focus more on general prevention and public health.
Tricia Brooks	Diabetes Advocacy AllianceTM	Overall, Type II diabetes rates are bad and progressively getting worse even though we largely know how to prevent it. Despite the thought in the public health community that the nation's prevention and wellness efforts should not single out one specific disease, her organization believes that the focus on diabetes is justified, given the compelling statistics on diabetes, the likelihood for diabetes to lead to other chronic conditions, and the potentially overwhelming cost to the healthcare system. We urge the Advisory Group and the Council as they draft the National Prevention Strategy to acknowledge the very real dilemma which is diabetes, the solution that the National Diabetes Prevention Program offers and make a vital commitment to prevent disease that already affects over 26 million Americans.
Terri Nally	American Association of Community Colleges	Community Colleges are a vital resource to the community with institutional missions committed to community development. More importantly studies show that community colleges are the predominant suppliers of the nation's healthcare professionals, particularly in the nursing workforce and allied health workforce. Also community colleges are a critical resource for ensuring health equity. The greatest number of minorities in the healthcare workforce goes through community college education programs. The AACC is willing to offer to the Advisory Group and the Council their resources on cultural change and promoting community wellness and education.
Vicki Shabo	National Partnership for Women and Families	The pillars that have been proposed look great; however, they do trend towards the individual level change, and the same emphasis is seen throughout the priorities. The Advisory Group and Council should consider the role of government and workplace policies in individual's access to preventive care, treatment for chronic conditions, and maintaining good health. Many of the priorities emphasize the need for preventative care, but it assumes that people can access these services when they really do not. Make the pillars more inclusive to people without access to care. Also the cross cutting health priority should include discussion about the disparities that exist for the relationship between paid sick days, paid leave, and preventative health. They are also pleased that sexual health is included in the Strategy as a targeted priority, and ask that the recommendations are broader to include empowering and education men and women to engage in healthy relationships and acknowledging that lesbian and gay, bisexual and transgendered people often need the disproportionate rates of depression and suicide that they experience addressed through healthy sex education and other services.
John Johnson	Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders	The Advisory Group and the Council might maintain a commitment to improving services and resources to LGBT older adults, who are often excluded from health policies that are meant to impact all population groups in the U.S.

Discussion of the Public Comment

Following the testimonies from the public, the chair opened up the floor for comments from Advisory Group members. Ms. Brown noted that the high quality of testimonies, and said she was struck by the issue of oral health in children. She added that children's oral health is a huge health concern and should be incorporated into the National Prevention Strategy. Dr. Levi stated suggested thinking about how to begin the crosswalk between traditional public health interventions and what will now be covered by insurance because of the Affordable Care Act in an effort to make sure nothing gets lost. Ms. Otto suggested that having an insurance card is not enough, that we can create access. She also suggested that those kinds of culture shifts can occur in our workplaces. .

Dr. Van Horn noted that sleep is important to consider and include into one of the following targeted priorities: workplace activity, healthy eating or mental health and emotional wellbeing. She added that the field of osteoarthritis incorporates a focus in complimentary medicine and she would like the National Prevention Council to consider incorporating it into the National Prevention Strategy, as well as complimentary medicine generally. Dr. Fielding added that the National Prevention Strategy offers the chance to address the major causes of disability and reduce the progression of disease, and advised the National Prevention Council to consider including secondary and tertiary prevention. Dr. Mayer-Davis pointed out that there is a need to include the definition of "community" in the context of the framework.

Dr. Bigby recommended adding a statement in the framework on where the impacts will be observed; there should be a way to describe or quantify the impact or potential impact of these broader policies even if they are focused on a specific issue or disease. Dr. Levi proposed using in the framework, the term "health protection," which he described as positive. Dr. Murthy asked the group to consider incorporating health impact assessment scoring in the National Prevention Strategy. Dr. Fielding said there is a report on conducting health impact assessment that is set to be released fairly soon. He informed the group that progress has been made in determining how to conduct health impact assessment, though it has yet to be perfected. However, he added that it might be worth mentioning in the framework, since the public health field is headed in this direction.

VI. CONCLUDING REMARKS 5:20 P.M.-5:30 P.M.

Dr. Levi thanked members for a productive discussion and for providing guidance on the National Prevention Strategy. He stated that they would continue discussion of the priorities at the next day's meeting. Dr. Benjamin also expressed her appreciation to the Advisory Group members for attending and sharing their expertise. She said that the CDC and OSG will work to include the Advisory Group's recommendations as they make revisions to the framework. The meeting was adjourned until the next morning at 9 A.M.

VII. DAY 2: WELCOME AND CONTINUATION FROM DAY 1 — 9:00 A.M. – 10:45 A.M.

Dr. Levi introduced the day's agenda and asked Advisory Group members for general thoughts about the previous day. Dr. Sharon Van Horn said that, while she liked the pillars image, she felt there was a need for more interconnectedness within the pillar image, perhaps wherever the areas overlap.

Dr. Fielding suggested having informal liaisons of the Advisory Group work with National Prevention Council members or their staff from the different agencies, to give members a better sense of the opportunities and challenges faced by intersectoral efforts. Dr. Levi agreed and added that members could think about how the members and the agencies both define co-benefits for various types of agencies and how to find a way to formally cement the culture change. Dr. Benjamin mentioned that the National Prevention Council had considered having combined meetings of the designees and Advisory Group members.

Sister Kerr stated that we need to ensure that our vision and goal are grounded and that the general public can feel themselves in it. Dr. Swider mentioned that, to encourage cultural change, several members were considering ways to have consumer groups that had submitted comments during the comment period sign on to the document and support it once it is completed. The organizations could use the document as a win-win with their members. Dr. Benjamin said that the National Prevention Council has reached out to stakeholders by holding town hall meetings and similar events with organizations, agencies, and various departments to gather input, and has continued to keep them involved throughout the process. Dr. Levi mentioned that the Advisory Group can demonstrate that broad support as part of the effort to protect the Prevention and Public Health fund and that many organizations have endorsed that. Additionally, he suggested they consider a sign-on letter when they discuss implementation.

Dr. Fielding then asked what process the members will use, if any, to look over the document in various stages so that all of the members will be on board with the final product. Dr. Benjamin responded by saying that the product should be released in June because the National Prevention Council's annual report is due by July 1.. Dr. Benjamin also mentioned that the National Prevention Council will determine how much of the document will be shared prior to release due to the issue of premature disclosure, but she hopes to share as much as they can.

Sister Kerr stressed the importance of integrative health in both the National Prevention Strategy and as new members are added to the Advisory Group. Dr. Levi suggested this is perhaps a topic for one of the working groups. Through working groups, the Advisory Group can have the capacity to bring other people to the table and incorporate their expertise. Dr. Levi said members should think about how preventive and integrative care can be incorporated into reform of the health care system.

Dr. Rosenstock asked how the members are expected to incorporate their input into the document. In response, Dr. Levi urged members to make notes on the document as they are traveling home and to submit them to the staff and the other members so that they could incorporate their input.

Dr. Levi turned the Advisory Group's attention to the section on "**preventing alcohol and drug abuse**." Dr. Fielding thought that the document should indicate that tobacco use is a major substance abuse problem and that it should be considered as one of the most dangerous drugs, whereas currently it is a separate section from substance abuse. Dr. Van Horn suggested adding early death or premature death to the harms of alcohol use, which would include underage drinking. She also suggested including a recommendation that supports college campus alcohol abuse policies because most of the binge drinking occurs on college campuses and the alcohol intoxication deaths are typically college students.

Dr. Bigby was uncomfortable with recommendation #2, which seeks to empower young people to avoid drinking or using other drugs. Dr. Bigby said that it is widely known that there are external forces promoting alcohol and other drug use among youth and there are policies that the government and others can implement to counter those forces. Dr. Levi added that it is the environment that individuals are living in and reacting with that can have an impact on the ability to be empowered.

Mr. Helms said that it may be important to tie substance abuse to behavioral medicine and disparity in criminal justice. Currently, a lot of our mental health and substance abuse services are delivered in jails. The increase in cutbacks for mental health services could cause an increase in the number of incarcerated people. It is important for the Advisory Group to consider the impact on county governments and others as they sustain the cost of jails with the shrinking budget for traditional treatment.

Ms. Semonoff agreed with Dr. Bigby's comments and she also pointed out that data suggest that, at least with respect to alcohol, adults provide a lot of the alcohol that young people have access to and the Advisory Group should address that issue.

Ms. Brown said that she is uncomfortable with the term "recommendation" because some of the recommendations seem more like guiding principles, which could give more latitude about what they are proposing. Ms. Brown offered the following recommendation: to support state, local, and tribal prevention, implementation, and enforcement in tobacco enforcement. By the time the counties are dealing with enforcement, they have already expended untold dollars in other programs dealing with prevention, implementation and treatment. Ms. Brown mentioned that her county has faced an issue in California when they passed a constitutional amendment in California to allow for medicinal marijuana, which has caused more problems than they could have ever imagined. Ms. Brown believes that marijuana needs to be incorporated because it is a much bigger problem than alcohol in Ms. Brown's county and in Northern California.

Dr. Levi said that, along with the notion about treatment, prevention, and enforcement working together, he would also propose that there be a principal recommendation about assuring that the Affordable Care Act creates access to substance abuse and mental health services and ensures that people are actually getting access to the treatment that they need. Dr. Fielding said that he does not believe that members are in a position to comment on the recommendations because they haven't seen them. CDC and OSG staff may have in fact dealt with the issues that the Advisory Group members are bringing up in the next iteration. Dr. Levi told the Advisory Group to think of the recommendations more as guiding principles and to opine on them in the sense of determining whether they are appropriate principles. Dr. Levi believes there will be an attempt to share iterative versions of the National Prevention Strategy.

Dr. Johansson said that it is important that the members do not approach the recommendations haphazardly but that they consider a strategy that can address the structural inequalities that affect populations that are disproportionately affected by the conditions in this section. He also concurred with Ms. Brown's comment on supporting state, local and tribal nation implementation of these programs and services. Ms. Barbara Otto expressed that she would like the Advisory Group to be cognizant of the interconnectedness between federal, state, and local programs and policies and how they may conflict. This needs to be addressed at some point in the National Prevention Strategy because there are several federal definitions and funding streams that may complicate enforcement for state and local governments.

Dr. Mayer-Davis noted that it seems that the National Prevention Strategy is lacking an introductory paragraph to the document. There is a vision for more synergy and cohesion regarding policies across the seventeen federal agencies,

and it may be more powerful if there is a more explicit statement that the National Prevention Strategy presents a new way of thinking.

Dr. Levi suggested that in addition to thinking about prevention, treatment, and enforcement, the Advisory Group should also think about supporting evidence-based services that would reduce the harmful effects of substance use. Ms. Brown mentioned that her county developed a new way of dealing with evidence-based interventions. They recognized that educational, nonprofit, and local government sectors are trying to incorporate new evidence into their practices dealing with at-risk kids, so they have developed an "upstream investment" policy.

Those sectors are asked to look at evidence-based practices and use them throughout their networks so that the outcomes are better across the board. The county has become the central source for providing evidence-based programs. The idea is to maximize outcomes by maximizing the agencies that are using the same evidence-based programs.

Dr. Levi summarized members' comments about the creation of synergy between agencies and programs including the alignment in the approaches that agencies take, while respecting the diversity of state, tribal, and local governments and finding a way to balance all of that out.

Sister Kerr said that the Advisory Group should also give consideration to the harmful toxins that can be found in food and water. Dr. Benjamin informed Sister Kerr that Dr. Graffunder is taking notes on members' comments and that the Environmental Protection Agency is at the table, noting everyone's input as well. Dr. Bigby suggested that it would be helpful to introduce the concept of the inverse pyramid, which includes populations who are particularly at risk, those who might be at medium risk, and the general public because the strategies for prevention are different depending on which population is being focused on. It would also require that we acknowledge over the life course that people might move up and down on that pyramid.

Dr. Levi then introduced a discussion of the "**healthy eating"** targeted priority area. Ms. Semenoff said that, although the nation is facing a time of challenging resources, the Advisory Group should try to ensure that recommendations are not made that would decrease access to health services and other resources, like food banks. Dr. Mayer-Davis noted that when she was looking at the healthy eating section, it seemed that throughout the section on healthy eating, there are references to both individuals and communities, and it is unclear. It would be helpful to have an explicit statement with regard to nutrition as it applies to individuals and the world they live in, but it also may be helpful to have a general comment cross cutting all these priorities about the balance between individual responsibility and the world we live in. Dr. Van Horn talked about changing the title from Healthy Eating to Healthy and Safe Eating to acknowledge some of the toxic chemicals found in water and soil. Dr. Van Horn also suggested adding dental disease as one of the risk factors for unhealthy eating.

Ms. Brown suggested that in order to address the needs of communities we need to evaluate the culture in which the resources are being implemented. Dr. Murthy suggested adding a statement about choosing fresh over processed foods in the first paragraph of the Healthy Eating section. Dr. Murthy would like to see a statement about decreasing promotion of and access to unhealthy food, as well as educating people on healthy food preparation.

Mr. Helms said that the Advisory Group should tailor language to show that not every practice is going to be proven or have a return on investment, yet can be impactful. Mr. Helms also stated that the medical system and public health community should collaborate more closely and start doing things that previously may not have been done in their

respective fields. For example, the medical system has access to vulnerable populations and can start incorporating public health approaches, like cooking lessons, into their treatment for individuals.

Dr. Van Horn suggested adding programs that promote breastfeeding and teach parents and caregivers about appropriate eating habits over the lifespan. She also advised including points about how the media and advertising affects tobacco, ethanol, and food practices.

Ms. Barbara Otto said that nutritional guidelines in schools should be implemented to improve school lunches and to reinforce nutrition education with parents. Dr. Benjamin responded that the Department of Education is working on physical activity in schools and the Department of Agriculture is working on improving food lunch programs.

Dr. Levi suggested that the National Prevention Council should ensure that a focus on where we live, work, learn, and play is being addressed in each section of the National Prevention Strategy. Dr. Levi added that the government could think internally about these recommendations, for example, to reinforce healthy eating requirements for government contractors in government cafeterias and for the purchasers and providers of food.

Dr. Fielding asked if the model developed for Healthy People 2020 would be integrated or incorporated into the document. Dr. Graffunder said that the CDC and the National Prevention Council can look at some of the models. Dr. Fielding said that a common base between the two strategies is needed; the Healthy People 2020 model would serve as a useful crosswalk.

Dr. Fielding asked if there were recommendations for research in the priority areas since each of the agencies, with some exceptions, fund research and evaluation. Dr. Graffunder said there was a decision to not set a research agenda in process in parallel to the National Prevention Strategy development process, but that there were considerations to include it in the implementation process. She added that Dr. Fielding's question could be part of thinking about priority research questions to be linked to priority actions and departments' commitments to those actions. Dr. Fielding responded that the issue of cross-cutting research and evaluation could be addressed in a separate document or highlighted within the National Prevention Strategy to make sure they are being handled in a consistent way.

Mr. Helms said that Grantmakers in Health is interested in convening agencies, organizations, and schools; he believes the National Prevention Strategy presents an opportunity for stakeholders to come together to forge common action and not just working solely within their constituency. Dr. Rosenstock suggested using a bolder generic approach that encourages the federal government to use innovative and evaluative actions to make up for gaps in the evidence base. Dr. Levi agreed that many people are talking about "evidence-informed", in addition to evidence-based, when considering actions. He suggested having working groups think about how funds from the Prevention and Public Health Fund could be used as an incentive grant to foster a collaboration between HHS and some of the other agencies in a few of these areas. Dr. Fielding proposed adding examples of success stories in the National Prevention Strategy that could serve as a catalyst and best practice for other organizations and agencies. Dr. Graffunder added that the National Prevention Council will include examples from local, state, and national levels and will use a set of criteria to identify those.

Dr. Levi introduced the discussion about the "**active living"** priority area. Dr. Rosenstock said the National Prevention should be careful about describing healthy versus unhealthy physical activity particularly in the workplace; for example, individuals may be doing heavy lifting all day that is not necessarily beneficial to their health. Dr. Mayer-Davis said that there is no mention of physical inactivity and screen time, which is important for children and should be included in the National Prevention Strategy. Dr. Van Horn recommended adding the phrase "people of all ages to

maintain a healthy body weight," as well as language about physical activity throughout the lifespan, and incorporating a principle to promote policies that improve education within families about how to incorporate activity into family routines. Dr. Fielding thought it would be useful to indicate the kinds of exercise and the range of physical activity for the aging population. Dr. Levi hopes that the cost benefits of a more active population are included in the context of this section. Dr. Murthy said that it would be helpful to find a way for communities to share best practices internally and among other communities. He also referred to an earlier statement about the need for health care providers to advise and counsel their patients on healthy eating and being physically active.

Dr. Levi introduced the priority of "**injury and violence-free living**." Dr. Johansson suggested that schools be added to the section, including bullying and school safety. Dr. Van Horn said adding alcohol use or abuse is crucial, due to the relationship of substance abuse to violence and injuries. Dr. Seffrin mentioned that programs and interventions are not aware of how to conduct robust evaluation. It would be helpful to encourage partnerships with those who have evaluation skills. Dr. Fielding said the National Prevention Strategy should make an effort to strengthen communities to facilitate social cohesion. He added that recommendation #5 should move up in rank to #1 because it is an overarching intervention among the different areas of emphasis. Dr. Fielding asked why unintentional poisoning is emphasized versus generally referring to the relationship with substance abuse. Dr. Swider suggested organizing the recommendations by levels of risk.

Dr. Levi introduced the priority area of "**sexual health**." He explained that sexual health includes reproductive health as well as sexual health. For example, when discussing preconception and prenatal care, that is not sexual health but is reproductive health. Ms. Otto asked whether the recommendation for education for youth would incorporate sexual and reproductive health education. Dr. Levi responded that it may be helpful to put in age-appropriate levels and to say that it is not only for youth but for all ages. Dr. Fielding said the write-up for this section might be changed if it is to include both sexual and reproductive health so that the section is more evenly balanced.

Dr. Levi mentioned the impact of mental health, substance abuse, and stigma in the context of LGBT health issues; he said this should not be placed under the sexual health section. He argued that it may be better to highlight those issues in the mental and emotional well-being section rather than for the sexual health priority area. Persons who are experiencing stigma, discrimination, etc are more prone to all types of risk-taking behavior, not just those related to sex.

Dr. Rosenstock said that this section provides an opportunity to make an important link between prevention and healthcare. She added that women's frequent contact with health care for preconception care can offer opportunities for other preventive care. Dr. Van Horn Sharon suggested including a statement about providing sexual health education for families to enable them to teach sexuality and reproductive health within the home.

Dr. Levi introduced the priority area of "**mental and emotional well-being**." Dr. Fielding said there is a missing piece about social well-being and social connectedness, which is critical for many of the outcomes that the National Prevention Strategy is seeking to address. He noted the concepts of "positive mental health" needed some clarification, and he also raised some speculation about the prevalence for mental disorders. Finally, he raised the point that most of the mental disorders listed are chronic conditions. Dr. Johansson said that the science base needed to be improved for perceived discrimination and health outcomes in the context of mental health, since it is not clear what the protective factors are against mental health disorders for individuals experiencing perceived discrimination and what the different mediating factors are.

Ms. Brown commented that there are certain objectives or guiding principles that cut across each of the targeted priorities, for example health equity, recognizing diversity, early childhood development, and others. These broad objectives could be stated under the pillars so that they don't have to be repeated under each priority area. She expressed her hope that in reviewing the National Prevention Strategy, the National Prevention Council would try to marry those things together.

Ms. Otto said that the guiding principles need to somehow acknowledge the health equity issue. She also thought that we need to address the alarming fact that mental health is always the first to get cut in a budget crisis. She raised the point that National Institute for Mental Health is funding biotechnology and not prevention and she asked whether prevention for mental health and emotional well-being is being funded the way it should be; whether prevention and those populations that need culturally sensitive programs and services are being targeted.

Dr. Van Horn suggested adding a guiding principle to decrease social isolation over the lifespan, and to introduce a guiding principle to provide education to parents on child development up to the time they leave home so that parents can recognize abnormal child development. Dr. Mayer-Davis will send some language that she would like to add to the pillars section. Dr. Bigby would like to introduce the term "emotional non-wellness" to the National Prevention Strategy as the concept of prevention in this area is not well recognized. She thinks prevention needs to be much stronger for this section. Ms. Otto asked whether there was more about prevention in the larger document and whether that could be shared with members. Dr. Graffunder affirmed that there is more about prevention; currently this is an area in which the National Prevention Council is struggling to develop solid content on "true prevention." They could use additional support from the Advisory Group.

Dr. Murthy said that the National Prevention Strategy recommendations should create a culture shift so people think proactively about their mental health and well-being as they may do about their weight or cardiovascular health. In being proactive, they start thinking about their work-life balance and social relationships. Dr. Murthy also said the mental health and well-being section is probably the most important section to include integrative therapies. Dr. Fielding said that Dr. Levi made a good point about community resilience and social issues that tie into that important concept. He suggested that preparedness and prevention should be nested somewhere in the National Prevention Strategy, perhaps in the injury and violence section. Ms. Semonoff stated that this section needs to include references to culturally sensitive programs. Dr. Van Horn would like to see children and adolescents included in the mental and emotional well-being section, which is currently limited to adults.

Once the Advisory Group had finished discussion of the priority areas, Dr. Graffunder provided an overview of the timeline for the next steps. Preparatory meetings can be set up and a small group can work on some parts of the National Prevention Strategy. Since any preparatory work needs to be presented to the full Advisory Group, a web-based meeting of the full body can be set up to bring forward the recommendations from the working groups. That meeting would need to be posted in the federal register for 15 days. The Office of the Surgeon General is also obligated to present the Advisory Group's recommendations to the full National Prevention Council on behalf of the Advisory Group or with the members present. The National Prevention Council can take them into consideration. The final National Prevention Strategy will then have to be finalized to get it into the departmental clearances. These steps need to be completed quickly and with tight turnarounds. The National Prevention Council made an explicit decision in their last convening to do an implementation planning process that would lead to much more specificity around the federal actions and the need to engage with sectors outside of the federal government and with state and local organizations and leaders. The Annual Status Report also offers an opportunity for updating the public on implementation.

Dr. Levi said he did not think there would be time for the Advisory Group members to complete another systematic review of the National Prevention Strategy. Once all of the members' input has been synthesized, there may be two or three areas where additional input may be of value. He suggested using a web-based platform to convene the members so that they can provide some of that focused input. Dr. Rosenstock said another effective mechanism to provide more input might be a small working group. Dr. Levi agreed and added that working groups will need to be determined depending on the members' expertise and interest in areas that need more development.

Dr. Seffrin said that the U.S. is faced with some of the biggest policy choices and there should be some serious thought to a boilerplate statement that explains why prevention is so important to the future of this nation, its public health, its economic stability, and potential prosperity. The nation will inevitably have to deal with issues such as an aging population accompanied by a tsunami of non-communicable diseases for which we will need to intervene. He stated that the question is then whether this population is alive and disabled or alive and productive. He also stated that we know how to intervene and that those interventions can have a return on investment. The boilerplate statement could be a one page statement of why health promotion and prevention is so important to the health of this nation. A strong statement can be put in the context of national security in making a compelling case for health promotion. Dr. Levi noted that Dr. Seffrin's suggestion was a perfect segue to the discussion about the roll out of the National Prevention Strategy.

VIII. <u>Moving Forward</u> 11:00 A.M. -12:45 P.M.

Discussion of the roll out

Dr. Levi commented that there is a lot that still needs to be determined and he anticipates that public affairs will play a significant role in the public roll out of the National Prevention Strategy. In an earlier discussion it was suggested that it might be helpful to develop a one-page statement of a vision for the Advisory Group. Dr. Seffrin proposed that this generic statement about the National Prevention Strategy could be articulated without releasing the specifics of the National Prevention Strategy. Dr. Levi agreed that a generic statement for the Advisory Group would be good and can be used as a mechanism to get support from each of their constituencies and beyond. The goal would be to have a broad base of support for the Surgeon General when she releases the National Prevention Strategy. Dr. Bigby recommended that the messaging should be along the lines of healthy schools, families, communities and workplaces will lead to a prosperous America and then go on to define the roles of the different stakeholders.

Mr. Helms praised this approach; he said that the messages need to be considered for different players, including public health, city government, county government, state officials, clinical community, integrative medicine community and academia. It is imperative that the expertise of all these groups be represented in the delivery of the National Prevention Strategy so they can see themselves in it and effectively reinforce the messaging when working with the federal government. Dr. Levi suggested a working group to craft messages. Dr. Murthy said it would be critical to gather input from the community, particularly on implementation; he asked about the best way to gather such input, given the short time frame. In the past, he has used conference calls, email surveys, and public forums. Dr. Otto suggested holding regional meetings to garner meaningful feedback and learn about the National Prevention Strategy.

Dr. Levi said there are many vehicles that could be used to garner input from the public and stakeholders. He informed the group that the most important thing is to gather individuals and groups from all levels and sectors and to be creative. He gave the example of the development of the funding announcement for CDC's Community Transformation Grants as a way to engage multiple sectors. He suggested webinars as an option for gathering input from these entities and additionally to have a member of the Administration on those webinars. Dr. Murthy

recommended that the group focus their efforts on generating ideas on what people could do locally to create ownership of the National Prevention Strategy, which could undo the impression of some of the public that the health reform law is just mandates coming from a central body. Dr. Mayer-Davis added that it would be important to involve the individuals who are receiving grants for these kinds of programs who can promote a grassroots and sustainable effort over time. Dr. Benjamin informed the group that they do not have to start from scratch with the roll out because HHS has an office that is responsible for ensuring that the roll out of programs involves all the key players. She, however, encouraged the group to provide input on how to improve the implementation of the National Prevention Strategy.

Mr. Helms said he's seen greater activity in the HHS regional offices, both in terms of their interaction with the Secretary and their interaction with their regional counterparts from other Departments. He thinks this should be part of the regional plan for engagement and implementation.

Ms. Brown sought clarification of the role of the Advisory Group in the development and subsequent roll out of the National Prevention Strategy. Dr. Levi explained that in the short term, one task of the Advisory Group is to provide feedback on the framework document. In the near term, the CDC and OSG staff will identify gaps and might convene the Advisory Group or form working groups of the Advisory Group to garner input on how to fill these gaps and address any emerging issues. The vision statement Dr. Seffrin described could be used at the time of the role to demonstration broad support for prevention. In reference to the format of the roll out, Dr. Benjamin explained that the National Prevention Strategy will be released to the President and some members of Congress. There will also be a media roll out. She added that they will be given enough information to prepare them for the roll out and that the real work begins after the National Prevention Strategy is released as they determine how to implement the strategies and ensure sustainability. Dr. Levi proposed the formation of a working group consisting of four to five people who will work with the White House to guide the media roll out process. He also reminded members that they can have a role as a member of the Advisory Group but also in their everyday role with their constituencies.

In the implementation phase of the National Prevention Strategy, Ms. Otto pointed out that it would be crucial to involve the regional offices in this process because they are the ones that states and other local public health entities turn to for guidance. Dr. Graffunder agreed with Ms. Otto's recommendation and added that the regional health administrators provided valuable service by convening public input during the public comment period earlier in the year. She acknowledged that the regional offices are fully capable of carrying out the proposed tasks. Dr. Swider shared that the regional meetings are a great starting point, but she challenged the group to involve the community groups, who will provide the push from the bottom up to keep this issue alive and move the process along. She stated that many of the community groups have already figured out how to work cross-sectorally, and the state and federal governments could benefit from their experiences. Ms. Brown reinforced her support for a vision statement or resolution from the Advisory Group as it would provide some credibility for them and that they participated in this process.

Dr. Fielding said there is a need for people to understand the purpose of the National Prevention Strategy, and that it is not a health strategy, but a prevention strategy. In particular, he said it's important to get this message to city, local and state elected officials to create the necessary culture shift to for prevention. He advised replicating the National Prevention Strategy at the state and local levels.

Mr. Helms commented that it is important to capture the simplicity of the Advisory Group's discussions in their actions and comments when they talk to the public. He added that the approach proposed by the group will yield great results, and he agreed with Dr. Seffrin's suggestion to have a one-page statement that will be shared with the

public about the National Prevention Strategy. Dr. Mayer-Davis added that the message of the National Prevention Strategy can be enhanced if we can point to existing examples of cross-agency prevention work – to showcase it can be done. Dr. Fielding stressed the importance of the co-benefit message – this work is not only important for those in the healthy community, but also for agriculture, transportation, etc.

Next Steps and Closing

Dr. Levi led the group in a discussion of the role of the Advisory Group moving forward. In the short term, the OSG and CDC staff will identify areas for which they need additional input. The Advisory Group will then form working groups to focus on these gaps. Additionally he proposed the formation of a working group that will craft the resolution for the Advisory Group. Everyone volunteered to serve on this working group. Dr. Levi noted that it would be helpful for the working group to develop this message in time for the upcoming webinar of the whole Advisory Group, if possible.

In reference to the long-term work of the Advisory Group, Dr. Levi suggested two working groups – one on the co-benefits issue Dr. Fielding mentioned and a second on prevention and integrative health. Part of the co-benefits working group can focus on how to form partnerships with other sectors and local constituents, and even building the relationship with other advisory groups. The second working group can focus on how community and clinical prevention and integrative health can fit into the reforming health care system. Working groups can include non-member participants and therefore can be a way to facilitate a dialogue with the other stakeholders and encourage people to start thinking more creatively. Dr. Levi informed the group that these working groups should be thought of rather as planning groups because they are not making decisions or creating products: they are creating dialogue. Then the deliberations of the working groups can be presented to the full Advisory Group. Mr. Helms suggested that the Advisory Group be sent a brief overview of the working groups and allow them to select which group they want to join.

Members will send Dr. Graffunder their email addresses and phone numbers, which she will distribute to the group as a whole. Regarding the request that was made earlier by the Advisory Group to receive talking points on discussing the National Prevention Strategy with their constituents, Dr. Graffunder said that those must be approved by the Office of Health Reform. It is her hope that the members will receive the talking points by email soon.

In closing, Dr. Levi thanked the members for their contributions. He added that he looks forward to working with them to provide input to the National Prevention Strategy. The meeting was adjourned at 12:30 P.M.