NATIONAL BIODEFENSE SCIENCE BOARD

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PUBLIC TELECONFERENCE

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WEDNESDAY
OCTOBER 14, 2009

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The meeting convened telephonically at 12:00 p.m., Chair Patricia Quinlisk, presiding.

MEMBERS PRESENT:

PATRICIA QUINLISK, M.D., M.P.H., Chair
RUTH L. BERKELMAN, M.D.
KENNETH L. DRETCHEN, Ph.D.
JOHN GRABENSTEIN, R.Ph., Ph.D.
JAMES J. JAMES, Brigadier General (Retired), M.D., Dr.PH., M.H.A.
THOMAS MACVITTIE, Ph.D.
JOHN S. PARKER, Major General (Retired), M.D.
ERIC A. ROSE, M.D.

EX OFFICIO MEMBERS PRESENT (or designee):

VINCENT MICHAUD, M.D., M.P.H., Director, Medicine of Extreme Environments, Office of the Chief Health and Medical Officer, National Aeronautics and Space Administration (designated by Richard Williams, M.D.)
JOSEPH ANNELLI, D.V.M., Animal and Plant Health Inspection Service, U.S. Department of Agriculture
COL JOHN SKVORAK, D.V.M., Ph.D., Commander, U.S. Army Medical Research Institute for Infectious Diseases, U.S. Department of Defense

EX OFFICIO MEMBERS PRESENT (or designee):

BORIS D. LUSHNIAK, M.D., M.P.H., Rear Admiral/Assistant Surgeon General, Assistant Commissioner, Office of Counterterrorism and Emerging Threats, Office of the Commissioner, Food and Drug Administration, U.S. Department of Health and Human Services
TERRY ADIRIM, M.D., M.P.H., Associate Chief Medical Officer for Medical Readiness, Office of Health Affairs, U.S. Department of Homeland Security (designated by Diane Berry, Ph.D.)

STAFF OF THE NATIONAL BIODEFENSE SCIENCE BOARD:

LEIGH SAWYER, D.V.M., M.P.H., CAPT, USPHS, Executive Director

A G E N D A

P-R-O-C-E-E-D-I-N-G-S

(12:03 p.m.)

CHAIR QUINLISK: Okay. Well, why don't we go ahead and take the roll call.

CAPT. SAWYER: Okay. I'll just begin by saying that I welcome the National Biodefense Science Board Voting Members, Ex-Officio, Speakers, and public in attendance.

I am Leigh Sawyer, the Executive Director of the National Biodefense Science Board. I also serve as the Designated Federal Official for this Federal Advisory Committee.

The purpose of this public teleconference is for the Board members to discuss recommendations presented to the NBSB on September 25th from the Disaster Mental Health Subcommittee, and for the Board to receive an update on H1N1 issues.

I'll begin with a roll call of the voting members in the NBSB. When I call your name, please respond. Patty Quinlisk.

CHAIR QUINLISK: Here.

CAPT. SAWYER: Ruth Berkelman.

DR. BERKELMAN: Here.

CAPT. SAWYER: Steve Cantrill. Roberta Carlin. Al Di Rienzo. Ken Dretchen.

DR. DRETCHEN: Present.

CAPT. SAWYER: John Grabenstein. Jim James.

DR. JAMES: Here.

CAPT. SAWYER: Tom MacVittie.

DR. MacVITTIE: Present.

CAPT. SAWYER: Thank you. John Parker.

DR. PARKER: I'm here.

CAPT. SAWYER: Andy Pavia. Eric Rose. Pat Scannon.

I'll call up the Ex Officio Member Names. If you're an alternate, please provide your name. Dan Fletcher. Carter Mecher. Larry Kerr. Richard Williams.

DR. MICHAUD: Vince Michaud for Rich Williams.

CAPT. SAWYER: Oh, thank you.

Frank Scioli. Joe Annelli.

DR. ANNELLI: Here.

CAPT. SAWYER: Willie May. John Skvorak.

DR. SKVORAK: I'm here.

CAPT. SAWYER: Thank you. Patricia Worthington. Dan Sosin. Hugh Auchincloss. Carol Linden. Bruce Gellin. Boris Lushniak.

DR. LUSHNIAK: I'm here.

CAPT. SAWYER: Diane Berry. Susan Haseltine. Rosemary Hart. Jeff Miotke Victoria Davie. Peter Jutro. Patricia Milligan.

Okay. We're checking our screen here. Oh, John Grabenstein, are you on? We see you connected, but maybe you're not able to speak. I know you're calling in from out of the country. If you have a chance to speak up during the call, let us know that you're on the line.

DR. ROSE: Leigh, this is Eric Rose. I'm on, too.

CAPT. SAWYER: Oh, great. Thank you, Eric.

DR. GRABENSTEIN: And John Grabenstein.

CAPT. SAWYER: Oh, good. Thank you. Has anyone else joined since I did roll call?

Okay. Let me proceed with just a brief overview.

DR. LURIE: Leigh, this is Dr. Lurie, so you know I'm on.

CAPT. SAWYER: Oh, thank you so much. Great.

Let me just do a brief overview of the Federal Advisory Committee. The NBSB is an Advisory Board that is governed by the Federal Advisory Committee Act. FACA is the statute that controls the circumstances by which the agencies or officers of the federal government can establish or control committees or groups to obtain advice or recommendations when one or more of the members of the group

are not federal employees.

The majority of the work of the NBSB, including information gathering, drafting of reports, and the development of recommendations is being performed not by the Full Board, but by the Working Group or Subcommittee, who, in turn, report directly to the Board.

With regard to conflict of interest rules, the Standards of Ethical Conduct for Employees of the Executive Branch have been received by all the Board members who, as special government employees, are subject to conflict of interest laws and regulations therein. Board members provide information about their personal, professional, and financial interests. This information is used to assess real potential, or apparent conflicts of interest that would compromise a member's ability to be objective in giving advice during the Board's meeting.

Board members must be attentive

during the meeting to the possibility that an issue may arise that could affect, or appear to affect their interest in a specific way. Should this happen, it will be asked that the affected member recuse himself or herself from the discussion by refraining from making comments, and leaving the meeting.

We will have two opportunities to provide public comment today from 12:40 to 12:55, and from 1:45 to 2:00. You will be given instructions by the operator how to signal that you have a comment, and your comment will be taken in turn.

The Federal Register Notice announcing this October 14 public meeting stated that any public comments could be addressed to the Board, and sent to the NBSB email prior to the meeting, so if you're not going to be giving your public comment in person today, we have received one email comment to-date, and that will be read during the public session.

I would like to remind everyone that this meeting is being transcribed. When you speak, please provide your name. The meeting transcript summary and public comments will be available on our website following the meeting.

Now, I'd like to turn this back to Patty Quinlisk, if you'd like, who's going to introduce our speaker.

CHAIR QUINLISK: Sure. I'd like to thank Dr. Nicole Lurie to be here. She is the Assistant Secretary of Preparedness and Response. I believe that some of you have had an opportunity to meet her at our last meeting, and welcome. And we're looking forward to hearing what you have to say. Go ahead, Nicki.

DR. LURIE: Great. Thanks.

I want to first say thanks again for continuing to meet regularly throughout H1N1. I think it's enormously helpful to hear what you have to say as you look over our

varied activities, and to get your feedback.

Obviously, as just reference, we had an opportunity to meet on September 25th, and had an opportunity to have a good exchange, which I think is really leading up to the agenda for this meeting.

During the first hour of this meeting, I think we're going to pick up this discussion that you all started on the Behavioral Health considerations for H1N1. And while I know that there have not been formal recommendations submitted yet, there was a lot of discussion in a number of areas, including interventions, education and training, risk communication, and vulnerable populations. So, consistent with what happened with not waiting for clinical data to fill and finish vaccine, but to act on the basis of very sensible discussion, I thought I would just let you know where we are with this.

There were a number of things that

were discussed. The first was to identify experts in behavioral health aspects of the Public Health messaging and risk communication. And we've done that, as well as identify experts with particular subject matter expertise in the vulnerable populations that we want to reach. We've done that, and have developed a roster of people to call on should we need additional advice.

Another recommendation, or emerging recommendation I guess I should say, was really to pull together a bunch of material for the behavioral health aspects of this posted on our website. That material has all been pulled together now, and is sort of in the final stages of vetting to go up on our website, flu.gov. So, I'm really pleased that that's moving forward, particularly, as we see increasing number of deaths, in particular, pediatric deaths. I think being sure that we can be prepared to meet the needs of people on the ground here is really important, so I

think we've been trying to be proactive in that.

And then, finally, to mobilize existing guidance materials that are out there for behavioral mental health providers, I think is also terribly important. And, again, our team, led by Dan Dodgen, who I know is on the call, has been very active in those areas, as well.

I know that the Disaster Behavioral Health Coordination meeting was held in September in Boston, and brought together a number of people and stakeholders involved in all this. And I'm sure he can share more with us as the meeting progresses.

The second hour of our meeting today sounds like we've had a series of changes due to the fact that the ASTHO meeting is in town, and I know that Commissioner Cooper and Secretary Selecky were originally going to talk about the vaccine rollout in their states, and provide some on-the-ground

perspective about what's going on. It does sound like now they'll be in a meeting with Secretary Sebelius, so we have asked Jay Butler, who, as I think you all know, leads the Vaccine Task Force at CDC, to provide a situational update, and to provide information about the current status of the logistics of the rollout.

As I think all of you know, last week vaccine started to find its way into states, which I think we're all very excited about. First up was the live attenuated virus, and then beginning this week, we'll start to see doses of injectable vaccine in states.

As you all know, I think it's going to be a slow rollout over the first couple of weeks, as vaccine comes into the pipeline, but are anticipating every week that more and more vaccine will be available.

After the discussion about the current status of the program, and the

logistics, we've asked Captain Clare Helminiak to provide a status report on medical surge capacity, sort of what we know about it, how we're monitoring it, and some of the activities that we've been undertaking here to stay on top of the situation.

As always, we'll welcome additional thoughts, and advice that you have. And, as always, in many ways sooner is better than later, as we continue to stay on top of this emerging situation.

I'm going to turn this back over to Leigh, and wish you a good meeting. Thanks.

CAPT. SAWYER: Dr. Lurie, thank you.

The agenda now calls for Patricia Quinlisk to do agenda overview and goals.

CHAIR QUINLISK: Okay. Thank you, Leigh. I think Dr. Lurie has left, but in case she's still on, thank you very much for speaking to us today.

Let me just go over the agenda.

And, as Dr. Lurie referred to, because of ASTHO meeting right now with the Secretary, both Mary Selecky and Susan Cooper will not be able to join us today. Jay Butler is going to go through some of the issues at his level. And if people are interested in a state-level perspective, I would be glad to give it from a perspective of Iowa. Obviously, here in Iowa, I'm very involved in all of that, so could give that, if we have time, and people are interested.

If you all would look at the agenda, you can see in the first part we're going to have Dan Dodgen and Betty Pfefferbaum talk a little bit more about the behavioral health considerations. And then, after that, then, again, going into the H1N1 vaccine issues. Towards the end of the meeting, we're going to be discussing the Draft Letter that all of you have had a chance, hopefully, to look at, and we'll have a comment on that, and a discussion. And then we will, hopefully,

wrap up by about 2:00 Eastern Time.

I think that's about all I needed to say about the agenda today. So, I think unless you have anything else, why don't we go on to start the discussion on the Behavioral Health Considerations.

DR. DODGEN: All right. This is Dan Dodgen, for those of you who don't recognize my voice. I want to thank Patty Quinlisk, of course, for her kind words, and her continued support of the Disaster Mental Health Subcommittee. And, of course, thank Dr. Lurie, also, for her remarks, and for her continued support of the Disaster Mental Health Subcommittee.

The Subcommittee appreciates the opportunity that the Board gave us at the September 25th public meeting to present recommendations on disaster behavioral health, and the H1N1 influenza pandemic. The recommendations provided on that date placed several of the main recommendations that you

had already reviewed and approved in the context of the current H1N1 threat. The recommendations taken as a whole provide a framework and emphasis for the work that ASPR and members of the Federal Family are carrying out to respond to the H1N1 pandemic.

It is also worth noting that there is a great deal of synergy between the NBSB Disaster Mental Health recommendations, and the recommendations on mental health in the interim report of the National Commission Children and Disasters, which is due to be released today. I don't know if it's official yet, but at some point today that should be coming out.

We particularly want to thank Dr. David Schonfeld, who's a member of both the National Commission, and the Disaster Mental Health Subcommittee. I think it was his effort that insured that these two very important documents move forward, and look the same, and that the recommendations have

synergy, as opposed to each one being on its own parallel track.

So, now Dr. Betty Pfefferbaum, the Chair of the Disaster Mental Health Subcommittee, is going to briefly review the recommendations presented to the Board on September 25th, including some more immediate actions that might be taken to forward those recommendations. Following her review, I'll highlight some immediate activity that ASPR, working with other HHS agencies, to begin to implement these recommendations, many of which will be similar to what Dr. Lurie was just talking about, as we continue our ongoing H1N1 response.

So, Dr. Pfefferbaum, I'm going to turn it over to you to just briefly remind the Board what we talked about on September 25th, and provide your remarks.

DR. PFEFFERBAUM: Great. So let me identify, or quickly summarize some of our recommendations from the September 25th

meeting, and then follow each with what we would consider important actionable steps that we would like to recommend.

For those of you who were at the meeting on September 25th, you may remember that we focused on three areas, interventions, training and education, and risk communication, and we emphasized our concerns about vulnerable populations.

With respect to interventions, we recommended a focus on interventions that resolve uncertainty, enhance resilience and coping, and foster adaptive behavior. We recommended attention to vulnerable populations, and we strongly urged the integration of Disaster Mental Health issues, and approaches into the larger Public Health response to this crisis.

With respect to actionable steps in the area of interventions, we recommend that you use our Committee, and other qualified professionals, and regional and local experts,

who we can help identify as an ad hoc advisory team of experts to provide reach-back capacity and guidance, and to help you address specific issues.

We recommend that you reach out to mental and behavioral health service providers through State Public Health, and Mental Health authorities, to promote attention to continuity of operations, and to insure that they have access to pertinent information and materials. And, again, we can help identify materials for you.

And, third, we recommend that you identify existing best practice, community resilience materials pertinent to H1N1, and make these available to Public Health and community leaders working in the area. And I think our group would be able to link you to the groups in the country that are working in this area.

With respect to training and education recommendations at the September 25th

meeting, we recommended identifying, developing, and disseminating existing best practice educational materials for mental health and medical providers, and for school personnel. We recommended working with Behavioral Health and Professional Guild Associations to reach some consensus on the status of psychologic first aid. We recommended disseminating information on coping and grief, including dissemination of information to the general public.

Four, actionable next steps in the area of training and education. We recommend that you identify and disseminate pertinent Behavioral Health materials that are relevant to the pandemic, and link these to flu.gov, and other websites, as appropriate. As Dr. Lurie mentioned, we've actually started this effort, and can continue to assist with it.

A second actionable step with respect to training and education is to urge federal and state health officials to identify

and be prepared to disseminate educational materials, and messaging about grief, and the particular stressors associated with the illness in children, and the death of children.

With respect to communication and messaging, at the September 25th meeting we recommended integrating Behavioral Health factors into all health messages, expanding the use of non-traditional communication, and addressing the needs of special populations in messaging, and sensitivity to terminology.

We have a number of actionable steps with respect to communications. We, actually, and as Dr. Lurie mentioned, our Subcommittee has actually begun to identify mental and behavioral health experts who can assist in developing these messages.

We recommend that you reach out to federal planners, risk communicators, and NGOs representing state and local Public and Mental Health to inform them of the importance of

anticipating and preparing for issues with high psychological impact, such as child deaths, perceived fairness and equity in cases of scarce resources, and potential mistrust of the government.

We recommend that you identify existing actionable guidance and education materials, and insure that those are available on the various websites, and in other formats.

We recommend that federal and state health officials promote the message that good health is good mental health, emphasizing that practical health activities, such as hand-washing, staying home when sick, et cetera, not only help to reduce exposure to and spread of the virus, but that they also have the potential to reduce the public's anxiety, and to foster adaptive behavior.

We recommend that you provide guidance to Public Health risk communicators, to insure unchecked health anxiety is addressed by refraining from the use of

certain terms, such as unique, or novel, when referring to H1N1, and to continue to reassure the public about the safety of vaccination. We suggest that federal and state health officials encourage the media to use images of community or national leaders as they are vaccinated to provide reassurance to the public. And we recommend that federal and state health officials be directed to work with Public Health risk communicators to discourage the use of terms such as worried well, which has an imprecise meaning in the context of this crisis, but, also, in general, in disasters and health crises. And, actually, this is an action that you may wish our Subcommittee to undertake to try to come up with, I think, probably not a single term that might be appropriate, but we might be able to provide some attention to what is actually meant when this term is used, and the different populations that it applies to. And, we might, also, be able to suggest some

new terminology.

And then, finally, at the September 25th meeting, we recommended attention to special populations, particularly those who are at risk because of co-morbid medical conditions, limited access to healthcare systems and services, those who have difficulty comprehending Public Health messages, because of a disability or cognitive impairment, or limited language proficiency. And we also recommended attention to, and continuity of operations planning for individuals who receive mental health and substance abuse services.

Actionable steps with respect to these vulnerable populations include, and Dr. Lurie mentioned, and Dan will speak in a bit to the fact that we are compiling a roster of subject matter experts with respect to these populations, and can forward those to you.

We also recommend that you encourage federal and state health officials

to reach out to traditional vulnerable populations, in addition to those who have been identified as at-risk with respect to H1N1. Thank you.

Dan, do you want to address more specifically some of the activities that your office and the Subcommittee have been working on?

DR. DODGEN: I'd be happy to do that. Thanks, Betty. I appreciate your remarks.

I'm sure that the Board will have a lot of questions or comments, so I'll try to be very brief. Let me just highlight some immediate actions that my office had asked for, which is known as the Office for At-Risk Individuals, Behavioral Health and Human Services Coordination, ABC for short, has begun to do to partner with the Subcommittee in moving forward these recommendations.

Two themes really appear crosscutting in these recommendations. The

first is the need to identify and mobilize Behavioral Health expertise to inform the current HHS response, and the second is the need to identify and mobilize Behavioral Health educational materials, and specific guidance for a number of important audiences, and vulnerable populations.

Regarding the first, we have begun working with the Subcommittee to identify experts in the Behavioral Health aspects of Public Health messaging and risk communication. We can then work with HHS' risk communication and public information offices to insure that these experts are available.

In order to meet the needs of vulnerable at-risk populations in H1, or in any kind of similar scenario, we have been working with the Subcommittee to compile an additional roster of subject matter experts in vulnerable, or at-risk populations that also could be called upon to inform the Board, if

they have specific questions regarding some of these groups, and the issues that the Board discusses.

To mobilize existing Behavioral Health educational materials, we have been working with the Subcommittee and other HHS agencies, to identify pertinent Behavioral Health materials, and link these materials to flu.gov. All those materials, as Dr. Pfefferbaum and, I think also, Dr. Lurie mentioned, have been compiled, and have moved forward to our Public Affairs office. And they're in the process of figuring out where the best place to hang that information is.

And then to mobilize existing guidance materials for Behavioral Health providers, again, we've been working with the Subcommittee and HHS agencies to quickly identify guidance materials and to reach out to Behavioral Health stakeholder groups to disseminate this material to their constituents.

We can talk more about what we're doing, but I think given that our time is running short, what I'd like to do is pause and allow time for discussion by the Board of any further issues related to Dr. Pfefferbaum's report.

CHAIR QUINLISK: Okay. Thank you, Dan. And I think you guys are doing a lot of work and a very good job. I appreciate all of the energy and activity that's gone on.

Let me go ahead and open it up to Board members for questions. And I will remind that when you ask a question, please identify yourself. Thank you.

DR. DRETCHEN: This is Ken Dretchen. Is there any move afoot to, basically, go directly to Boards of Education at state-level or county-level in terms of dissemination of information that would be appropriate for various grade levels from K-12?

DR. DODGEN: This is Dan. I can

begin to respond to that, but certainly welcome other people to jump in as well. And I think one of the things that has been a hallmark of this H1N1 response has been the integration of the Department of Education at the federal level, as well as at local and state levels into the overall response. You may even remember the big H1N1 summit that Secretary Sebelius hosted, I guess it was the end of August now. Actually, it was the Secretary of Education, Secretary of Homeland Security, and the Secretary of HHS all were present there really as a sign to everybody that this response was really going to focus on educational settings, because of the high impact on children. And I think as you look at educational strategies, messaging strategies, you are seeing that.

Now, of course, how that's working at individual levels, probably other people on the call could speak to better than I could. But, certainly, the message from the federal

level is absolutely to include Departments of Education. And I know, for example, Susan Cooper wasn't able to be here today, but I know, for example, in the State of Tennessee, they are very much including their Departments of Education in their efforts to reach out to people with information about H1. But I'll pause in case there's anyone else who would like to respond to that before we move on to another question.

DR. DRETCHEN: This is Ken Dretchen, again. Where I was -- I mean, I know what the federal governments are doing. I was just curious in terms of whether you get feedback at the state level to what's actually going on on the ground with the educational materials, actually go to the kids or their families.

CHAIR QUINLISK: This is Patty. I might be able to answer just a little bit of this. There has been a lot of stuff coming down in the federal level and then I know a

lot of states are working with their state Boards of Education with a variety of things. I think the real question is how much of it is actually filtering down to individual schools, and going out to individual students.

My feel, at least in Iowa, is there is quite a bit of that going on, but perhaps not as much as we could. We're still getting a lot of concern back from parents on the safety of the vaccine, and the fact that the flu seems to be mild. Why should I be worried about this? So, I'm getting the feeling that more education, probably, would be appropriate, especially on the vaccine.

I think there's quite a bit of information out to the school-age children, though, about covering your cough and hygiene and all of that. I think that's been covered. My biggest concern right now is just the vaccine, and acceptance rates.

DR. SCHONFELD: This is David Schonfeld. You know, the one thing I would

add is that there is material that's been circulated about hygiene issues and trying to prevent transmission. And there has been some -- but there's been much less limited, and I'm aware of very little information going around about the Behavioral Health aspects, and what the implications are, if peers are sick, what this might mean to your own health and well-being, and what about in cases where they have been deaths that have occurred of students. So, I'm not sure that that information, the Behavioral Health part has been covered much in the material that's gone out to the educational groups.

DR. DODGEN: This is Dan. I think this question and the responses really speak to the fact that the communications plan that exists at the federal level and at most state levels, I think, are actually really well thought out and comprehensive, but that the gap often occurs at the actual level of implementation at the local level. And I

think that that's -- I think it's a great question, and I think it's probably something that is worth us continuing to ask, and perhaps even when we get to the public comment period at the end of the call, there may be some folks who represent local communities who can tell us more about how that's working really at the very local level.

DR. JONES: Yes. Dan, this is Russell Jones. Just as a follow-up, I was wondering is there any tracking system or systems in place to see the extent to which information is being used and actually impacting individual's behaviors and subsequent outcomes?

DR. DODGEN: That's a great question. I know CDC has actually been paying a lot of attention to this, so I might defer. I don't know who's on from CDC, if they would want to respond, or perhaps that's something that we could allow them to respond to later, because I know Jay is talking later and it

might be part of his remarks.

All right. Not hearing anything, maybe -- I think it's a great question, Russell. Let's see if we can drill down and get some information back to you at a later time. But I think the answer is yes, CDC is looking at that.

DR. PARKER: Dan, this is John Parker. You know, the -- first of all, I applaud your group and I really like your recommendations. And what we're really up against here is that we're a victim of a lot of years of inattention to the value of the Public Health Services across the country. And, although we have a group here that's working extremely hard and coming up with things that -- recommendations that need to be implemented, the bottom line is that out there in the states and the local communities, the Public Health Departments are so strained at this present time, it's almost a stretch for them to be just talking about getting people

to come and get the vaccine, and stress its safety and stress that type of marketing. And, although the public needs support on these issues that your group is talking about, I just think they're totally out-stressed, and people -- there's not people to go do this. I'm terribly worried that the -- you come up wonderful implementation ideas, and they're very hard to implement because of a manpower problem.

CHAIR QUINLISK: This is Patty Quinlisk. I would second that, especially, to be honest, in these economic times, most states are actually laying off workers in Public Health, and everything. And it does become a stretch. You end up doing what you have to do, and not what you should do. So, that is an issue, but it's probably a larger issue than we can deal with just this. But on that same line, to be honest, Dan, it might be -- if you want specific action at least taken at the state level, it would be very useful,

at least from my perspective at the state, of saying here is the specific information. Here is exactly what we want you to do with it and this is the highest priority. It makes it more doable, than having to basically sit down and figure out exactly what it is you should do to try to implement some of these action steps, to be told exactly what that thing is and exactly how you would do it quickly.

DR. JAMES: This is Jim James. I think as long as we look at it in the context of what John and Patty were saying, as a Public Health responsibility, we really will get nowhere. And I think when we're talking about mental health, resilience, whatever terms are most appropriate, I really think we're talking about a much larger integrated system, Public Health an important part of, but only a part of.

And then the second point is, the kinds of recommendations we're looking at are terribly difficult to implement. They're

impossible to implement almost in the short term. And I think the work of the Disaster Medicine Health Committee -- Mental Health, needs to be looked at from a strategic perspective, not in the context of H1N1.

DR. JACOBS: This is Gerry Jacobs. I wanted to make a similar comment, I guess. If we're looking at things that can be done in the next couple of weeks, it's really hard. But I think the last couple of comments really point to the importance of some of the recommendations that were made on the 25th about establishing a work group to begin the process of moving forward with more community-based models of psychological first aid, where we get this information out. That's going to take a very long time, but this is the time that we can get started.

DR. PFEFFERBAUM: This is Betty Pfefferbaum. And I would say that we can and should use this experience to do as much as we can to address the need in the context of

H1N1. But, also, to prepare for future events, so that we're better ready, and have better strategies and better recommendations the next time.

CHAIR QUINLISK: This is Patty Quinlisk, again. I'm wondering if it would be doable even to have some kind of -- this is the number one, number two, number three priorities. Here are the specific things that state or local Health Departments can actually do. Here's where the information is and here's what we think you should do with it.

To be honest, being in the middle of H1N1 right now, I love the ideas of what we need to do in the future and I totally support that. But, right now, we're not going to take action on that stuff at the state level, because we're too overwhelmed with H1N1. But I do know that there are a lot of people out there concerned about some of these populations, concerned about risk communication. And I'm just wondering if we

could do something a little bit more on a here's what you can do in the next 10 minutes kind of thing, for the state and local Health Departments, that would make it easy for them to act on.

DR. DODGEN: This is Dan. Let me try to respond to that. First off, of course, I think it's Dr. James that said part of what we're struggling with is that a lot of the big picture recommendations, we're still in the process of implementing, so it makes it very difficult to come up with a quick term solution, when we haven't yet built the overall integration of Public Health and Mental Health systems, so it's hard -- if the systems, and the integration of the systems hasn't been completed yet, it makes it a little bit more difficult to do some of the quick turn-around kinds of things.

Having said that, I do think that several of the comments speak again to the importance of making the information that's

already out there available to as broad a spectrum of both providers and individual citizens, as possible, particularly given that there really is a lot of really, really good information out there. Some of it's been developed by members of the Subcommittee, some of it's been developed by other colleagues known to all of us on many of the issues that we're raising right now about helping people cope, as Dr. Schonfeld talked about, cope with both grieving and with what you do if someone you know gets sick. There's really, really good information out there. And it seems to me that, perhaps, based on this discussion, what might be something that would merit further consideration could be, how do we improve our ability simply to get already existing really good information into the hands of the people that really need it? Because I do think some of this is out there, but, clearly, it's not making its way into the hands of individuals who could most benefit

from having it.

DR. PARKER: This is John Parker. And I really appreciate the comments and everything that followed my kind of archaic comment. But the -- I think the way that this could be implemented just a little faster is that we take into account that the Public Health Departments are focused on a real time mission of getting vaccine out and getting people in. And they don't have a whole lot of time for this. And then backing up on Jim James' notice, it might be encouraging if we would recommend, perhaps, that our recommendations be forwarded to the presidents of the professional medical societies, and that they possibly help us communicate these recommendations to their memberships, so that the providers become aware of what we're trying to do. And as they see patients, they can use parts of our recommendation to bolster the mental resilience of the patient population, or their beneficiary populations.

And besides going to the professional societies, maybe we could send a letter to the major healthcare organizations with these recommendations.

I agree with everybody that's spoken. This is very, very important, and maybe in this particular instance, we're not just -- we're dealing with the entire provider community, rather than just Public Health.

CHAIR QUINLISK: This is Patty Quinlisk, again. I think within the context of this group, it might -- since, basically, our action is taken by sending recommendations to the Secretary, I wonder if the thing to do is to try to get, if we could, sort of from, Dan, your group and Betty, the Subcommittee, and all the people working in this area, some very defined steps that we could send through recommendations to the Secretary of what needs to be done, and then suggestions of how to get that information out to the American public through places like professional

organizations, or whatever. I think we would need to do it that way, rather than the Board going directly to professional organizations. But I'm going to stop for just a second, and, Leigh, have you weigh-in here and see if my concern here, interpretation is correct.

CAPT. SAWYER: I think the Board could write, and I think this was what Dr. Parker was suggesting, that the Board write a letter to the Secretary suggesting that this information be shared with these different professional societies.

I wonder if the members would like to be thinking about the approach they want to take to these recommendations. And if we could take a minute to have the operator ask whether there are public that want to make a comment, because we are entering the public comment period. And Dr. Dodgen wanted to ask for some input from a couple of people from the Department in terms of how we're spreading this message. So, maybe over the next few

minutes there'll be an opportunity to come back with a proposal.

MS. MICHAEL: Leigh, it's Gretchen Michael from ASPR, a couple of things. There are mechanisms that are -- that the Department and the CDC use to communicate directly with the medical professional associations, as well as individual physicians. They do a weekly, if not more than weekly, COCA call, and have been providing ongoing information to clinicians, as well as to medical groups and medical societies for their distribution to their membership. It has a very, very large outreach, so there are mechanisms in place to get information out, if the Board determines that they do want to make some recommendations, and have those sent out.

And then, secondly, just back to a previous question about communicating with schools, and Education Departments, and superintendents. There has been -- as Dan mentioned, since the beginning of this in the

spring, there has been very close working relationship with the Department of Education. Arne Duncan and Secretary Sebelius have been out there continually, have had a number of conference calls with school superintendents, with principals.

Additionally, when the school guidance came out, both the toolkit for schools, as well as the handouts for students, those were sent out, I believe by DVD, to all the school principals, and were distributed through the Principals Association. So, there has been ongoing communication with schools, with principals. And there are a number of things in terms of Public Service announcements, which are geared towards children, the Elmo ads that have been done. There's going to be a "Sid the Science Kid" episode on H1N1, which actually is going to be premiering on the 26th of October. There's going to be a preview of that at the Department of Education for employees and

their children, as well as others, on the 21st. And it's also going to be available to be shown at vaccine clinics in schools and basically to get the vaccine. So there's been -- we've had a very close working relationship with Department of Education as this has moved along.

DR. DODGEN: Thanks, Gretchen. I think that's very, very helpful. And one of the things I wanted to say, too, was that all the efforts that Gretchen was just describing really do include information about mental health, and about coping, as part of the overall strategy.

What we want to do now is give the operator a chance to make the request of the public for public comment, so we begin queuing those up. Once that's done, I'm going to turn to turn to Stephanie Zaza from CDC, and ask her a follow-up question.

OPERATOR: At this time, if you would like to ask a question, press star and

the number one on your telephone key pad. We'll pause for just a moment to prepare the Q&A roster.

DR. DODGEN: All right. Thanks, again. And for those of you who don't know Gretchen Michael, who just spoke a minute ago, she is the Director of Public Affairs. I think that's the right title. But, anyhow, the Public Information Officer for ASPR. And I think most of you probably know Stephanie Zaza, as well, who works in Public Health Emergency Preparedness at CDC. And I believe is -- is she representing Dan today? I'm not sure. But, anyhow, we're very glad that you on, Stephanie.

And the question that had come up earlier was whether -- to what degree we're monitoring the success of our outreach efforts, particularly in schools, but perhaps in other settings, as well. If you might be able to speak to that a little bit, I think it would be very helpful.

DR. ZAZA: Sure, am I open, is my line open now?

DR. DODGEN: Yes, we've got you.

DR. ZAZA: Great. Thank you. This is Stephanie Zaza. I'm the Senior Advisor to the Director of CDC's Coordinating Office for Terrorism Preparedness and Emergency Response.

Over the summer, as you all are aware, we developed a number of guidance documents for community settings that really did focus on behavior change, and things that organizations could do to facilitate that behavior change, particularly schools, colleges, universities, childcare settings, and businesses. And we developed all of those documents in direct coordination and collaboration with our partners in the other Cabinet Departments. And you heard from Gretchen about a number of major efforts that were undertaken to move those documents and that information out to organizations that could continue to spread that information and

help people take action.

We are in the process of monitoring the success of our communication efforts in a couple of ways. We have -- as many of you may be aware, there's a project at the Harvard School of Public Health that uses polling methodology to look at behaviors, knowledge, intent among a random sample of Americans. And it is able to really get some very interesting data on what people intend to do, what they are doing, what their beliefs are and so on. So, we're tracking, to some extent, able to associate some of those responses with our communication messages, and looking to see how those behaviors change over time.

We also have put in place some monitoring information through the Behavioral Risk Factor Surveillance System, that's particularly looking at vaccination intent, and vaccination receipt. So, that will be going on throughout the season, but that will

be an ongoing module within our usual BRFSS mechanisms at the states.

And then, finally, for specifically around schools, we set up a school dismissal monitoring system that looks at whether or not schools are closing. As I'm sure you're aware, we don't currently recommend that schools close, except in very specific situations, given the current severity and situation of illness. So, one way to look at whether or not our messages are getting through is to look at the number of school closures. And what we've seen are very small numbers, although it's not zero. And those numbers and locations of school closures tend to follow where we see the highest disease rates. And that tended to follow where schools opened, as the school season started back up in the fall. So, it was a small number of school closures. And compared to the spring, where we saw very direct impact of our guidance. When we suggested schools close,

we saw a lot of schools closed. As soon as we changed our guidance to not recommending school closures, school opened again, so we do see that sort of very robust reaction to guidance documents, and the ability to get that information out to the public. So, that's sort of an interesting outcome measure looking at a particular intervention, not necessarily the Behavioral Health intervention, but one that clearly impacts a lot of people's behaviors and their stress.

So, there are a number of things in place, and that's sort of a highlight and we'll be communicating that information back out to our partners as we receive that data continuing throughout the season.

DR. DODGEN: Thank you.

DR. ZAZA: Dan, one other thing I would suggest to the Subcommittee is that if there are particular indicators of social-level determinants of stress in the system, and behavioral impact, that we could add to

the survey mechanisms, but that would be something that we would be very open to do. These surveys are ongoing, as I said, but they can be -- we have a core set of questions, but they could be changed. We could be adding questions over time.

DR. DODGEN: Thanks, Stephanie. That's a very generous offer that the Board may wish to take you up on. I'm not sure, but we really appreciate it, appreciate the incredible information and your willingness to speak up to that on this call.

I'm going to turn it back to Leigh, who I think is going to queue the operator up.

CAPT. SAWYER: Yes. Operator, I see that you have a number of people in line for making public comment. I would like for the public comment to be specific to this half of the agenda, so if you have a comment that does not relate to the topics that we've been considering here, Behavior Health Considerations for H1N1, I'd prefer that you

wait until the second hour, when we have public comment between 1:45 and 2:00. So, Operator, can you have the first person ask their question.

OPERATOR: Yes, ma'am. Your first question comes from the line of Deborah Robinson.

DR. ROBINSON: Yes. Hi, Dr. Deborah Robinson of Robinson Consulting. I have two comments. First, in relation to the second actionable next steps to support communications, I would strongly, strongly suggest that in addition to the federal planners, risk communicators and NGOs representing state and local Public and Mental Health, that you include the state and county-level VOADs, Voluntary Organizations Active in Disasters. I've made this comment before.

This is really essential, because these groups are working on the ground with vulnerable at-risk populations every day. Also, many of the members of VOADs already do

disaster mental health counseling, grief, et cetera, so they just need the H1N1 take on it, but they're all over the country, so that's important.

The second comment relates to the vulnerable population section. I would like to suggest that someone -- I don't know if someone is systematically tracking H1N1 hospitalization and death rates by racial ethnic group, but I don't find they're reporting on this very clearly.

The MMWR that reported on the Chicago study, while possibly the most significant finding was that children age 5-14, 14 times more susceptible to the virus than older adults. It was also found that African Americans, Hispanics, and Asian Pacific Islanders were four to five times more likely to be hospitalized than Whites. And in an MMWR released in early September, it was reported that children with neuro developmental conditions are at increased

risk, but the same study found that 50 percent of those pediatric deaths were African American and Hispanics. And if this pattern is true, it would be extremely important for this to be communicated very clearly, and very boldly, as it would tremendously assist in convincing African Americans and Hispanics to get the vaccine.

I work in the communities on the ground and the reticence is that they don't see that people are dying, and they may see people getting sick, et cetera, but they were very -- I think this would be a very motivating factor if this relationship is not true. Thank you very much.

CAPT. SAWYER: Operator, let's go to the next question, and we'll have the Board to respond to all these, so that we can keep on our time frame here.

OPERATOR: Your next question comes from the line of Don Bennett.

MR. BENNETT: Yes, I'm Don Bennett.

I'm a teacher in Los Angeles, and there's been rumors out here that there is an antiviral called Peramivir, that's effective in hospitalization, severe cases of H1N1. And I just want to know if that's true, if that's a possibility that we could investigate, and help us with students that are real sick. Thank you.

CAPT. SAWYER: Operator, let's go to the next question. We'll cover that in a few minutes.

OPERATOR: Your next question comes from the line of Paul Gordon.

MR. GORDON: Hello, this is Paul Gordon. I'm out here on the West Coast in San Francisco. Maybe just a little dovetail to Mr. Don Bennett's question. And the whole area of behavior and communication, I hear the emphasis on the front end management of this entire national/international crisis, but one of the frustrating elements is that at ground zero, which is inside the intensive care units

that are being overwhelmed with acute influenza cases, we have a huge missing link, which is the need for an IV-administered antiviral. In fact, that can be emphasized with a recent case of a doctor trying to use, I believe it was Relenza combined with an inhalation form of administration, where it caused a death, because it was a non-approved use.

In this whole process of communication, the issue I bring up is, there is an antiviral, as mentioned, called Peramivir, which has shown tremendous results in treating acute influenza, and is an IV-based solution, and is available under an EIND process through BioCryst Pharmaceuticals. This tool in a poll informally with ICU medical professions is just an incredible need, yet there's nothing on the CDC website that references this, makes it known to the medical community that it's available. And, in fact, it really brings up the real

question, given the pandemic, and a declaration of the crisis that we have, why, in fact, an emergency use authorization has not been issued for this antiviral. And, in fact, we have international members that are moving faster than our own country, and this is particularly in Japan, where, in fact, it has gone through Phrase III trials.

CAPT. SAWYER: Thank you so much for your comment. This is Leigh Sawyer. We will need to take those two questions to the second hour of this meeting, since they relate more to the intervention, the countermeasure interventions. But are there any further discussion points? I know we have no more public speaking -- no more public comments in the queue.

Patty, I'm going to turn it back to you.

CHAIR QUINLISK: Okay. I guess what we need to do at this point is the Board needs to decide what we want to do, whether we want

to act on what has been presented, et cetera. So, I want to open it back up to the Board for what you feel the appropriate response is, at this point.

DR. BERKELMAN: Patty, this is Ruth Berkelman, and I just want to respond to one comment before we get into that issue. It was Dr. Robinson's comment, I believe. And I would want to encourage CDC to put out death and hospitalization statistics frequently, and in more detail. I've heard this comment before, and I would encourage that.

CHAIR QUINLISK: Okay. Thank you, Ruth.

Why don't we go back to the Disaster Mental Health Subcommittee. You all should have the recommendations in front of you, and, hopefully, all heard some of the discussion. And let's open it up to what we feel is the appropriate action for the Board to take at this time. Not hearing anything, let me make -- well, let me ask Dan a

question.

Given the discussion that we had here today, both Dan and Betty, what kind of action are you requesting that the Board take at this point?

DR. DODGEN: This is Dan. I will certainly defer to Betty, if you want to say anything; otherwise, I'll make some comments, but I'll allow you to go first, if you'd like.

DR. PFEFFERBAUM: Oh, go ahead, Dan.

DR. DODGEN: All right. Thanks, Betty.

I think that many of the recommendations I think really are in a format that they could be included in broader recommendations, which could go forth from the Board to the Secretary. So, I think the ones that fall in that category, I think really are contingent upon further actions that the Board takes in terms of bigger picture recommendations, et cetera, that they may be sending to the Secretary.

I think there are a couple of specific recommendations here that would make a lot of sense for the Board to task the Subcommittee with, if it's something that is agreeable to the Board. One thing is, I know this term "worried well", has come up a couple of times in communication, and there's been some expression by the Board at, particularly, the meeting on the 25th, that it would just be nice if we agreed how we want to talk about this in the future, since we keep saying don't say it, but we don't say what to say instead. I think that might be something very -- could actually have a really significant impact on future messaging activities, if the Board were to task the Subcommittee to work on that issue.

I think, also, Dr. Zaza from CDC has brought up an interesting issue, which is whether or not there are some specific items related to Behavioral Health that might be added to some of the existing surveillance

instruments. I think that that would certainly be something that would be worth our time thinking about, because that would be something that could not only have an immediate impact, but, also, could have impact over the long-term. I think in terms of activities that are manageable, that have a specific outcome, and a specific deliverable, I think those would be two very appropriate activities for the Subcommittee to work on.

I think the bigger picture is of the great list of recommendations that the Subcommittee has come up with related to H1N1, I think, perhaps, the future steps might be simply to take those action steps that the Subcommittee has come up with, and systematically go through them in a way that says here's the things that we believe action can be taken on immediately. I don't think it's worth taking time for the Board to vote or discuss on that now, but I think, certainly, we could come up with which of

these were handled, didn't get handled, could be done better in the future.

CHAIR QUINLISK: Yes. Dan, this is Patty. I'm going to just make a personal comment on this.

I really applaud all the work you've done, and I think it's very good. I think, given the discussion that I heard today, and what I've heard you say, I sort of see there's two different things. There's one of what we need to start working on now, so in the future we are better prepared to cope with situations like this.

On the other hand, we might be able to come up with some very specific steps that could be done easily, and immediately to deal with the situation we're facing today. And I'm wondering if we could sort of think of it that way, and see if there's things we could pull out of these recommendations that, for example, could be set up as recommendations from the Board to the Secretary, saying here's

what we think you need to do in the next week, two weeks, or whatever. And here's the very specific, not saying, for example, go to this general website, but here is the exact tool that we think is the best that could be used right now, that kind of thing. And I guess I'll just throw that out to you, and the Board, and see if you think something like that could be done fast enough, that it would be of practical help with the situation right now.

DR. JAMES: This is Jim James. I think Patty really hit on the head, going back to my previous remarks. I think part of the difficulty is pulling out what we can and should do now in the short term, and then this much, much more difficult strategic issue. And, I think if the Subcommittee can really take the time to, at this point, focus on the short-term H1N1 impact possibilities, and get that to the Board, and up to the Secretary, I think, potentially, we can still achieve

something good.

DR. DRETCHEN: This is Ken Dretchen. I totally concur with those comments.

DR. REISSMAN: This is Dori Reissman from CDC. Can I just add one kind of request in there that I think might help the group in some of its own deliberations?

There's been a lot of information that's been generated during the response, generated by various epidemiologic investigation teams that CDC has been a part of, learning a lot about what could be measured during the different implications of school closures that happened in South America, which happened in the United States, and in Japan. And if there is a way to share some of that data with the Disaster Mental Health Subcommittee, it might yield a more informative recommendation in the near term, rather than trying to do things in a bit of a vacuum.

CAPT. SAWYER: This is Leigh Sawyer. Patty, I might make the suggestion that it seems that there's not a specific document, or specific list of items that you want to put forward to the Secretary at this time. This is what I'm hearing. If by the end of the call we could revisit this, I know that Dr. Butler is on the line, and Dr. Clare Helminiak, and they actually have a very short time they can be available with us. So, I'm concerned about trying to rush this, when it seems that there's still a lot of conversation to be had. And I'm anxious that we are able to start the second half of the meeting.

CHAIR QUINLISK: Yes. Thank you, Leigh, for bringing that to our attention. I think you're very right. Let's go ahead. We'll put off more discussion until the end, and maybe that will give Dan and Betty a minute to sort of think about what's been said. But let's do go ahead, and go to the second half of our meeting. And I think I'll

just go ahead and introduce Jay, who's the Program Director of the H1N1 Vaccine Task Force, and then Clare Helminiak is the Deputy Director for Medical Surge, both at CDC. Excuse me, Jay is at CDC, and Clare is at HHS. Could we go ahead and have the two of you give your presentations. Thank you.

DR. BUTLER: Thank you, Patty. And good afternoon, everyone. This is Jay Butler. And I just want to say that I am joined by Susan Cooper, the Secretary of Health from the State of Tennessee, and Mary Selecky, the Commissioner of Health from the State of Washington, who had also been asked to participate today to give you a little bit of the view from close to the front lines in the state perspective.

But my recommendation, Patty, if that's okay, is reflecting back on the initial agenda might be for me to give a very quick situation update, and then turn it over to Susan and Mary to give us a little bit of the

viewpoint from the states. Would that be okay?

CHAIR QUINLISK: Yes. Jay, go ahead. And I'll just say, Mary and Susan, thank you for joining us today. We were understanding that there might be a little bit of a conflict, but we're so glad to hear that you were able to join us. Jay, go ahead.

MS. SELECKY: Well, we're missing your boss' speech to ASTHO, so this is an important topic for us. But Secretary Sebelius, I just greeted her, and brought her in. This is Mary Selecky.

DR. BUTLER: All right. Well, on that note, let me start with a quick situation update on the status of the pandemic.

During the past really six weeks, we continue to see nationally an increase in the amount of influenza-like illness. There was only one week where there was a brief decline, most recently another increase again. The level of influenza-like illness measured

as a portion of all visits to single providers that are due to influenza-like illness are really very similar to what they were at the peak of the 2007-2008 seasonal flu outbreak, at a little over five percent. And, actually, are greater than the rate was at the peak of the 2008-2009 seasonal outbreak.

As we look across the country, 37 states or jurisdictions have widespread, the highest level of influenza activity, and overall, 47 have either regional or widespread, which is the highest levels of influenza activity.

The most -- the epidemiology of disease hasn't changed from what it was during the outbreak last spring, as far as continues to disproportionately impact children, younger adults with underlying illnesses, and pregnant women. The elderly, in general, have lower attack rates, in a certain sense are spared, although when the elderly do become infected, they are at high risk of complications.

As you may have heard last week, using the Pediatric Death Surveillance, 76 deaths in children related to H1N1 infection has been reported, and additional deaths have been reported during the past few days.

So, if I could summarize the epidemiology of the situation report, we're seeing a total number of ILI cases, similar to what we see in a typical February with seasonal flu, the groups at greatest risk are similar to what was seen in the initial H1N1 outbreak last spring.

Looking to the Southern Hemisphere experience, the risk groups that have been seen in the Southern Hemisphere during the Austral winter was very similar to what we've seen in the U.S., both during the initial outbreak last May, and during the increase during the past month.

The virus, itself, has not undergone any major changes in terms of major increases in antiviral resistance, or changes

in antigenic characterization. So, the good news is, at least still at this time, we would have a good match between the virus that's circulating, and the vaccine.

If I can move on briefly to a vaccine update, as of yesterday, over 11 million doses had been allocated to the states for ordering. A little more than half of that has been ordered, and is either in shipment, or has been delivered and is being administered. And orders continue every day as this process moves on.

Of the vaccine that's become available for ordering, a little more than half is injectable vaccine now, which just became available a little over a week ago. And most of that is in multi-dose vials. A little over five million doses are available as flu mists, the live attenuated vaccine.

We continue to be ready to monitor coverage. I think to this group I described the system that's set up for BRFSS to be able

to look at state coverage, as well as coverage in certain risk groups. Also, we started the weekly surveys using the 2009 H1N1 Flu Survey, which is similar to the National Immunization Survey, except there is not a check of medical records. It actually started that during this past week, to be able to assess both seasonal flu coverage, as well as coverage with H1N1 vaccine, and intent to be vaccinated. A little over 500 participants. I think the very good news is that less than one percent reported they've received the H1N1 vaccine, which I say is good news, because this survey was actually administered before vaccine was available to the public in any sector. So, one of the limitations of this methodology is the potential for recall bias, and that was certainly reassuring. Sixty-one percent of the participants reported that they will probably get, or definitely get the H1N1 vaccine, if it becomes available to them.

With that, I think I will actually

stop my situation report, and turn it over to -- actually, which one would want to go? How about I turn it over to Secretary Cooper, we'll start in the Southeast and move to the Northwest.

MS. COOPER: Well, thank you, Jay. And thank you all for having us here today, because it really is a great opportunity for us to give you a front line view of what it looks like from a Commissioner or a Secretary's chair. And there is some good news, and there is some challenging news out there. So, I'll start with the good news.

All of the investments that were made into preparedness planning for all types of disasters has really paid off. And had we not been able to plan, to exercise our plans, to refine our plans, the states would not have been able to respond in the manner that they have. And the good news is that in Tennessee, and I think Mary will tell you the same thing, in Tennessee, our plan is really working. And

we're ecstatic about that.

We spent lots of time and actually built a model program, which we do believe is a best practice around provider pre-registration for the distribution of this vaccine, or other types of countermeasures. We used our vaccines for children's programs as the base, which had about 500 provider-types in that system. And more than 1,200 providers across the state pre-registered with our State Department of Health, stating their intent to give this vaccine. And when we use the number 1,200 - that's not a fixed number. For example, a pharmacy, or a grocery store chain that has a pharmacy, like a Kroger's, would register once, but they may represent 50 or more sites across out state. So, these numbers, the 500 plus the additional 1,200 are an under-estimate of the private providers who want to participate, and do not include the hospitals, who also are receiving vaccine. And that model, again, was replicated across a

number of states.

You know, we've seen that orders were varying in size, and we do have some concerns that some of the provider input was somewhat unrealistic. For example, ordering a dose for every patient in the practice, or every healthcare worker, so we have some challenges around counting, and trying to insure that we don't double count folks.

We also have some complexities related to the allocation of vaccine. Based on our priority groupings, in relationship to the type of vaccine that's being distributed. For example, as you all know, the majority of vaccine that we have received is mist, and it's not appropriate to deliver that to pregnant women, children, or adults with chronic disease. And, certainly, it has given us an opportunity to manage through complex times. And, hopefully, come up with simple solutions to complex problems.

You know, there was also some

challenges with the number of shipped to sites that the states were allocated. For example, we couldn't deliver to all 1,200 sites, but we were able -- because we were limited on the number of places we could have vaccine sent by McKesson and FedEx, but the CDC really supported our request to add additional sites, which has been modestly helpful in trying to, again, get our vaccine out to different places.

DR. BUTLER: Maybe I could just interject here. I didn't mention this in the update. In previous presentations, we've discussed the 90,000 ship to sites. We've been able to get that increased to 150,000 nationally, so that that provides you a little background on what Susan is referring to.

MS. COOPER: Yes. So, for the good news, we've ordered everything available to our state, and it's getting to our provider's offices timely. We don't have any shipments sitting on a dock somewhere. There's been

great coordination with CDC, and with McKesson and FedEx to insure that once vaccine hits the ground, we are able to very quickly get it either in the nose, or for the injectables, in the arms of a Tennessean. So, I guess, just other high-level concerns or challenges that we face is this topic of managing expectations, because we have to manage expectations on multiple levels. You know, in our communities, in our counties, in our states, at our administrative executive levels, in our un-states that again at the federal level.

You know, we know that the general public is anxious, and some other challenges we face is how do we mitigate the misinformation? When you look at communication at the state level through the media, we've been very fortunate that we have not had some of this fear mongering that's going on about the safety of the vaccine. We've included the media as partners in our

state. And I think that's worked out really well for us, but it gets very difficult when you can go to a national news media and find misinformation. So, it's a challenge, just for us to acknowledge.

And I think the public health infrastructure, we have done well with what we have. But as funding for public health has diminished over the past few years, the public health system weakened. That is not a statement that says we can't do this, because we can do it. We have fabulous relationships, and partners across each of our states. And this is something that is getting done without a blink of an eye, but I would urge all of you to take a look at what these funds in the past have prepared us to do, and consider that when you're making your recommendations.

And with that, I'll turn it over to Mary Selecky, and we'll be happy to answer questions.

MS. SELECKY: Susan, I thought you

might take a moment and just describe Tennessee's public health system, because I think it's really important for the Board to understand how different we might be, but how we have the same job.

MS. COOPER: All right. That's great. So, Mary's state, and my state look very different. The state of Tennessee has 95 counties, and we touch eight contiguous states, just to give you an idea of what the state looks like. In those 95 counties, the State Health Department is the local Health Department. And then in six counties, we have local control, or local boards of health. So, for the majority of the population in Tennessee, the State Health Department is a direct provider of services.

And in Mary's case, I'll let you jump in.

MS. SELECKY: So, this is Mary Selecky, and I'm the Secretary of Health in Washington State. And to just set the stage,

as you go from the Southeast to the Northwest, Washington has multiple international borders. They include the water, the air, and then our partners to Canada, the Northwest from where Jay Butler really continues to have his home, and we hope he gets back there. The Northwest works very well together, that includes Alaska, Washington State, Oregon, Idaho, our partners in Montana, Alberta, the Yukon Territory, because that's how our populations move very easily.

And, in fact, I was with Governor Gregoire, our Governor, and the Premier of British Columbia, Gordon Campbell, last week. We signed yet again another Memorandum of Understanding for us to very easily exchange data about the epidemiology, and, in fact, about issues around communicable disease with no question about exchanging that. So, you can see that our setups are a little different geographically.

In our state, it is a very local

government-based state. If you look at the Washington State Constitution, the local public health authority has authority over its citizens in a way that I do not as Secretary of Health. We have 39 counties organized into 35 local health jurisdictions, who report to boards of health made up of elected officials, mostly county councilmen, or county officials. Our counties range in size from 2,200 population to over a million. But Susan and I both have the same responsibilities, as did Jay when he was in Alaska, that really have to do with bugs knowing no border or population density, or part of the country.

I want to pick up on, and not repeat, the things that Susan said, particularly, answering your question about state and local perspectives. And I'm going to come at it slightly differently.

Some of the challenges that we have facing state and local public health include economics. And I do have to state that.

First, I will start out with a thank you, a thank you to the President, and Congress, and HHS for, number one, investing in the vaccine production. And, number two, investing in the Public Health infrastructure to make sure that we were able to move into the kind of response that we need to have going on.

But in the economics, as you look at it, state and local health are faced with the biggest reductions in recent history. I testified in front of our legislature recently, particularly about H1N1. I was asked if I was worried. And the reason I answered yes, is because local health has 330 less full-time equivalents, many of those being public health nurses. They have 330 less in 2009 than they had in 2008.

The next question was, are you going to be able to meet this challenge? And, as Susan said about her state, absolutely, because public health will step up to the mark. We will stop doing non-essential

services. We will ask for forgiveness later when we move people around in the department, and that's happening at the state and local level across this whole country. It is a time when public health will shine, but they're going to be very, very tired at the end of the day. And it needs to have the continued support by state, local, but also federal kinds of action, including funding.

Second point on economics are the schools. They face similar issue. For most districts, H1N1 is extra work, that they don't have time or resources for. They're focused on getting kids educated, and kids tested, and their schools to meet the mark that the Department of Education puts on them. And we had a meeting with our Superintendent of Public Instruction, who informed us that many schools don't even have money to pay for extra cleaning supplies. I mean, we have very good information in our tool boxes about just some extra cleaning of hard surfaces, but that's

not been in their budgets.

A second major one is clearly the overcoming the fears of a new vaccine. And Susan, well, we have worked with the press, too. We have a very interesting history in the Northwest, that has to do with that frontier mentality.

DR. BUTLER: Your senator hasn't gone mono with Bill Maher, though.

MS. SELECKY: No, not at all. So thank you for -- Senator Frist going on one-on-one with Bill Maher, but Glenn Beck is from Washington State. And my understanding is that Glenn Beck perhaps isn't the best supporter of vaccines.

We, in Washington State, have had a tough thimerosal law. I have the authority to waive that, and I did, and my email box, of course, filled up immediately. But the -- calling this a new vaccine has added to the confusion, and we have to call it a new vaccine, but we're spending a lot of time

explaining it's made the same way, the same thing Dr. Fauci says, I say multiple times every day.

The Harvard study shows that only 50 percent of parents say that they're certain they'll get their kids vaccinated. We have a lot of work to do. About 40 percent of the adults say they'll get vaccinated. We have more work to do.

There are general vaccine safety concerns, and we have to be prepared, and our providers need to be prepared in a very different way to explain that. There are a lot of different confusing details to the public. And then we're getting hit with this seasonal flu vaccine lack of availability, and it's just adding to the confusion. And information, understandably, changes in real time, so when I go, and my home community is a very rural community in Northeast Washington State, north of Spokane, Washington, near the Idaho panhandle, just to give you an idea, and

when I walk through the Hallmark shop, or go to church, or I'm at my rotary meeting in Colville, Washington, when I'm there, I'm spending my time with my neighbors making sure I'm sorting it out for them.

That's the kind of job you're getting from state and local public health. We absolutely appreciate the bully pulpit messages from the federal level.

Last week a call was held with governors, and the encouragement that's coming from HHS is to post all kinds of information on our websites. And I think we're doing that, short of one thing, the location of clinics. And you need to understand, it's not because we haven't planned clinics. It's not because we aren't going to have clinics. It's not because we haven't signed up providers, because in Washington State we have over 2,000 providers who will provide this vaccine, including retail chains, pharmacies, et cetera. It's that we want to make sure that

when we say to the community you all come, like Susan says, you all come, that we're there at the ready. So the vaccine that has arrived in Washington State is getting into health care workers, it's getting into children.

We filed our first report in terms of the ages of the first vaccine, and the administration. The train is moving down the track. We are very proud of the work that we are doing. More importantly, it's about preventing a disease that's preventable, because the number of people that are hospitalized in Washington State continues to go up. Last week we had 42 hospitalized for flu, more than half were typed with H1N1, and they are very sick, and they're young. So I think Susan and I would be happy to answer any questions about the on-the-ground.

DR. JONES: Yes. This is Russell Jones. I just had a question. Well, thanks so much for your very thorough report. But a

question concerning points of misinformation that Susan shared.

MS. COOPER: Is there a specific question, or just to clarify further?

DR. JONES: Yes, clarify further. What were the points of misinformation, and how is that being dealt with?

MS. SELECKY: And Russell, could you tell us -- just give us an idea of who you are, and what you do?

DR. JONES: Yes. I'm Russell Jones. I'm a professor and clinical psychologist at Virginia Tech University. And I do a lot of trauma-related work concerning children and fires, the Virginia Tech massacre, as well as Katrina.

DR. DODGEN: Russell is also a member of the Disaster Mental Health Subcommittee.

MS. COOPER: Right. Thanks. So for example, we are spending an inordinate amount of time talking about this vaccine

being made just like the seasonal flu. It's a seasonal flu vaccine for a second seasonal flu season. They just happen to be applying at the same time. That the risks of the vaccines are the same as the seasonal flu vaccine. But there's this misperception that keeps getting heightened in the media that this vaccine was rushed to market, that corners were cut, that there's some special way this vaccine was made, different from the seasonal flu, that we're waiting on more safety studies and clinical trials related to the safety of the vaccine, which are different than what you do for the seasonal flu vaccine.

DR. JONES: Yes.

MS. COOPER: And then you have a number of national media who appear to be not supportive of vaccines, in general, so when they come out on the national news and give a message that is different than what we are pushing as the trusted communicator about the health of our public. I mean, we have a

serious job to protect, and promote, and improve the health of the residents of our states. And we take those jobs seriously. Most of our citizens and residents believe that, but then you get a talking head saying well, they're lying to you.

DR. JONES: Yes. Yes.

MS. COOPER: So again -- and very learned folks are getting on as the expert of the moment. So that then complicates the messaging.

CHAIR QUINLISK: I'm sorry, this is Patty. I'm going to interrupt for just a second. I'm sorry, but I understood that Clare needed to leave quickly. Is she there? Do we need to give her time to speak?

CAPT. SAWYER: No. Actually, She had to drop off the line, so we'll try to get a medical surge briefing at our next meeting.

CHAIR QUINLISK: Okay. Thank you, Leigh, and please now go ahead with your conversation.

CAPT. SAWYER: Patty, did we lose people? I just want to be sure to have an opportunity for the Board members to ask questions of our guest speakers.

CHAIR QUINLISK: Yes. Why don't we go ahead and do that. Does anybody have questions either for Jay, Mary, or Susan? Not hearing any questions, why don't we go ahead and see if there's any discussion points, or issues that people want to discuss on, basically, the whole issue of some of the H1N1 vaccine issues that we've just heard updates on.

I may just -- this is Patty, again. I may just start the conversation by saying that I agree with what both -- well, actually, everybody said. There's a lot of misinformation out there, and I think anything that can be done at the national level, or with non-governmental speakers, I just think would be very, very helpful. I feel like I've spent most of my last couple of weeks just

addressing all the misinformation, rather than truly getting the right message out.

MS. COOPER: Patty, this is Susan. Can you hear?

CHAIR QUINLISK: Yes. Go ahead, Susan.

MS. COOPER: You know, actually, when we talk about communicating, as well, if you remember, we presented the work that ASTHO did around vulnerable populations, and one of our chapters was really about how do you reach those folks that are at risk, not at risk of getting the disease, but at risk of some of the downstream things that might happen. So this idea of a trusted messenger, I really think we have to go back and revisit. So I support what you're saying about we really need to be as crisp as we can on the messaging, without setting up false expectations, or unrealistic expectations. And Mary alluded to that. We've got great plans for the clinics, but we can't tell you

the day we're going to run it, because we don't have the day we're going to have the vaccine yet.

CHAIR QUINLISK: Yes, I agree. It's a very delicate balance beam that we're walking here. And yet on the other hand, we've got to get information out soon, otherwise, nobody shows up at all.

MS. MICHAEL: This is Gretchen Michael, the Communication Director at ASPR. I think, also, one of the things that I know some states are doing is, even if you don't have the exact locations of the clinics available, or the dates, having at least something on the site that says this is where you'll find it, keep checking back, or check back in a week, or something like that, so that your communities know where to go for it, and where to keep checking, and to have that information, to put that information out, obviously, in your local media, as well.

The other thing I was just going to

say was, in terms of the misinformation, I think we're all fighting that. You've got loud voices who are -- sort of have differing opinions from what the public health community is recommending. You know, the best thing to do is just to continue to put out good factual, accurate information using credible messengers, as we all know. And we're trying to do that. We have a myth and a fact section on flu.gov, where some of these things are addressed. And I will give some credit to some of the national media. The networks have really done, by and large, an excellent job of trying to dissuade some of this misinformation that's out there. And they're doing stories every single night, so they, too, have been our partners.

We've done a series of media tabletops, one in New York most recently, one here in D.C., and it's been attended by the local and national media, as well as the Secretaries and representatives from the CDC,

and Director Frieden, and it's been attended at very high levels. And I think it's been educational for both sides, both for the political leadership, as well as the media to understand what we're all up against, and the role that each of us play, and how we can have that symbiotic relationship, how we can help each other.

CHAIR QUINLISK: Yes. Thank you very much. Are there any other comments from anyone on the Board?

Okay. Leigh, let me just ask you a quick question. Next on our agenda was the letter, and I'm just wondering, should we stop this discussion at this point, and go to the letter, or do you feel like we need to continue with this discussion, and come up with -- see if we want to have any recommendations, or anything come out of what we just heard?

CAPT. SAWYER: I think it certainly would be up to the Board members, if there

were comments that they want to discuss now. I think in terms of the agenda, we can move on to the Draft Letter to the Secretary, if there are no other comments on this discussion. And I personally want to thank Secretary Selecky, and Commissioner Cooper, as well as Jay Butler, for pulling yourselves together there away from the ASTHO meeting to find a quiet spot to be able to share with us, with the Board the experience that you have. And I know the Board very much appreciates the time that you've committed to this. And I'm sure Secretary Sebelius will forgive you, so thank you.

CHAIR QUINLISK: Yes, I'd like to add mine, too. This is Patty. Thanks for coming up today, and sharing with us. I think this is very useful. And let me give you one last chance to add any comments, or any suggestions, or anything you would see that the Board could do to assist some of the issues that you're having to deal with out

there in the states. Maybe they dropped off. Okay. Well, I think they may have dropped off.

So let us go ahead, and let's talk for just a minute about the Draft Letter to Secretary of HHS. I believe that all of you had a chance to take a look at it, and both with some of the suggestions that were made from people. Let me open it up and see if anybody has any more comments right now. Either nobody has comments, or I've dropped off the line.

DR. DRETCHEN: No, this is Ken. I mean, as far as I'm concerned, the letter with its edits, I think is good to go.

CAPT. SAWYER: Patty, you might want to read the letter and describe how you received comments, because I don't know that everyone has a copy of the letter.

CHAIR QUINLISK: Oh, okay. Let me read the letter to you then, as it stands right now. It says the Members of the

National Biodefense Science Board have been closely following the planning, production, and testing of the vaccine for 2009 H1N1 influenza pandemic, as well as the National Pandemic Preparedness and Response efforts, in general.

The Board members have expertise in a broad range of disciplines. We have had extensive briefings from experts in government, industry, academia, and other domains providing opportunities to understand the preparedness and response process in detail.

We strongly support the National 2009 H1N1 Immunization Program, based on the overwhelming evidence that the benefits of vaccination far outweigh any potential risks. We strongly encourage the early voluntary immunization of all high-risk Americans, followed by the vaccination of all others who would like to be protected from this infection, as the vaccine supply grows over

the coming months.

The vaccines have been produced using the same processes, standards, facilities, and manufacturers as the seasonal influenza vaccines. Seasonal vaccines have an excellent safety profile, and has been given to many hundreds of millions of Americans since the 1940s. We anticipate that the 2009 H1N1 vaccine will have the same safety profile, similar to the seasonal vaccine.

In addition, we are pleased with the systems being used to monitor safety. We are concerned that many people have been confused by rumors, myths, and unwarranted fears. We appreciate the work you are doing to dispel these myths. Sincerely.

Okay. So let me ask, does anybody have any comments on that? I'm going to just real quick, I did receive some comments in the mail. I'm going to just see if I received comments from anybody who is not here today, just to make sure that some of those people --

let's see. I did get a comment from Andy, I believe Andy Pavia is not on the line. Is that correct? And he was in support of the revised version, and would, basically, support its continuing up the ladder with those revisions.

Let's see. Steve Cantrill is not able to be here, but he also sent me an email saying he agreed with all the changes. Let's see. I believe everyone else is actually here that sent me comments. So let me stop a minute, and just see if there's any further comments on this letter.

DR. BERKELMAN: This is Ruth Berkelman.

CHAIR QUINLISK: Yes, Ruth. Go ahead.

DR. BERKELMAN: And I also agree with the letter. I think it's a good letter. I probably would not include the last paragraph. We don't specify which myths. I'm okay if it goes forward with this in it, but I

do want to point that out, that it -- I don't think it's necessary to the letter. See how others feel.

CHAIR QUINLISK: And I'll just add my personal thanks, just as somebody who's had to be dealing with all these -- I do feel that, at least from my standpoint, to offer continued encouragement of trying to deal specifically with some of those rumors and myths at the national level is very helpful to us out in the states. So I guess my vote would be to leave it in.

DR. BERKELMAN: Maybe we should just take out the word those, dispel myths, rather than dispel those myths, as if there are specific myths we're talking about.

CHAIR QUINLISK: Okay. I think that's probably a friendly change. Other comments?

DR. ROSE: This is Eric Rose. I think that with the small modification, it should stay.

CHAIR QUINLISK: Okay. Any other comments? I think what I'd like to do then, is go ahead with a formal vote with the amendment that the last line would say we appreciate the works you are doing to dispel, maybe we should say, these rumors, myths, and unwarranted fears, and just go back to the original statement.

DR. BERKELMAN: Again, I would not include these. I just -- if you want to go back to that, I would say -

CHAIR QUINLISK: Okay. So just dispel myths, rumors, and unwarranted fears. Okay. Because we would want them to dispel the rumors and the unwarranted fears, too, not just the myths.

Okay. With that modification, maybe, Leigh, we should go ahead with a vote. Is that correct?

CAPT. SAWYER: Yes, that would be fine.

CHAIR QUINLISK: So I'll let you

take the roll with the vote.

CAPT. SAWYER: So what we are voting on is the letter as just read by Dr. Quinlisk, with the change in the last sentence. So do you agree with sending this letter forward then as a recommendation to the Secretary, or the letter, as written, to the Secretary. Patty Quinlisk?

CHAIR QUINLISK: Yes.

CAPT. SAWYER: Ruth Berkelman.

DR. BERKELMAN: Yes.

CAPT. SAWYER: Steve Cantrill.

CHAIR QUINLISK: He is not here, but he sent me the email voting for it to go forward.

CAPT. SAWYER: Okay. Roberta Carlin. Did you receive an email from her?

CHAIR QUINLISK: I do not believe so.

CAPT. SAWYER: Okay. Al Di Rienzo. Ken Dretchen.

DR. DRETCHEN: Yes.

CHAIR QUINLISK: Oh, I'm sorry. This is Patty. I did receive one from Roberta saying she supports it going forward.

CAPT. SAWYER: Ken Dretchen.

DR. DRETCHEN: Yes.

CAPT. SAWYER: John Grabenstein.

DR. GRABENSTEIN: I vote yes.

CAPT. SAWYER: Jim James.

DR. JAMES: Yes.

CAPT. SAWYER: Tom MacVittie.

DR. MacVITTIE: Yes.

CAPT. SAWYER: John Parker.

DR. PARKER: Yes.

CAPT. SAWYER: Andy Pavia.

CHAIR QUINLISK: He also sent me an email saying yes.

CAPT. SAWYER: Eric Rose.

DR. ROSE: Yes.

CAPT. SAWYER: Pat Scannon. Okay. It looks like you have full approval, unanimous vote.

CHAIR QUINLISK: Great. Okay.

Thank you. So we now have that going forward. Why don't we go back, and in our last 15 minutes, what I would like to do is first open it up to go back to the discussion we were having about the -- how we would like to have recommendations from the Behavioral Health, Mental Health work group to go forward, and what we would like to see that -- perhaps a format of that. So I would like to open that back up to discussion from Board members for just a few minutes, and then we'll go to public comment.

DR. PARKER: Patty, this is John Parker. I would recommend that the letter of recommendations from the Disaster Mental Health group go forward with a cover letter saying that attached is the full recommendations of the DMB, but we recommend that maybe one, two, and three of these items be given a higher priority than the whole report.

CHAIR QUINLISK: Okay. And I agree

with you. I would like to see, though, if we say one, two, and three, that they be very specific, high-priority, and target with action that could be taken immediately, and easily by those people who are asking to take action. That would be my suggestion.

DR. PARKER: Yes. And Patty, because of that, I would recommend that we allow the Committee to work that, and that we not vote completely today on the delivery of the report. I don't see how we can do that without seeing that cover letter.

CHAIR QUINLISK: Yes, and I would agree. And since most of the report talks about more long-term kinds of things, I would -- again, my suggestion would be that we wait until we have those specifics, so that those are the ones that could be acted on quickly, that those are ready. And then we can -- the other ones, since they're more long-term, those can be forwarded on at a later time. What do other people think?

DR. JAMES: I totally concur. Jim James.

DR. MacVITTIE: Agree. Tom MacVittie.

DR. DRETCHEN: Ken Dretchen, agree.

DR. BERKELMAN: Ruth Berkelman, agree.

DR. ROSE: Eric Rose, agree.

CHAIR QUINLISK: Okay. Well, it sounds like to me what we need to do, both for you, Betty, and Dan, if we could ask you to go back to the Subcommittee, ask them to pull off a few, three, five, whatever you think appropriate, specific pieces off of that with, again, targeted action that can be taken at whatever level you recommend. And that, perhaps, we could have those back in enough time that we could look at them, and then perhaps vote on either if we feel that they're emergency enough, we could actually, I believe, do an emergency vote, or at our next public conference, which I believe is in

November. Leigh, is that correct?

DR. DODGEN: This is Dan. Let me just clarify. Thanks for the feedback on all of these issues.

The way that the paper that you have in front of you developed was, it started, of course, with phone calls back in, I don't know, June, July, whenever we first got on. We were asked to develop the recommendations that came forward. The most recent document that you have, which I believe was also on the public site, so I think everybody has seen it, includes the actionable items, where working with the Subcommittee, my team took the recommendations and turned them into actionable items, working, obviously, with Betty very closely on that. And that's what Betty reported on today, was the recommendations, and then the actionable items, and how those might be concretized. So I'm not really sure what further work could be done on these.

I understand the Board's desire to see things in as concrete a format as possible, but I feel like that's been done. And I'm thinking the next step is, at our December meeting, which will be coming up in about five or six weeks. I mean, it's not very far away, that we really look towards beginning to think about long-term strategies.

I'm a little concerned if we keep trying to focus on immediate H1N1 response, that it may not be the best way to use the Subcommittee, because I think we've given you our thinking about that, and some concrete strategies. But I don't think we can keep doing -- okay, next week we're going to do another immediate. Here's some additional things. Next week we're going to do another one. I'm a little bit concerned that that may not be the best use of the Subcommittee, and may place an undue burden on my staff, which has to end up then being the ones who really pull it all together.

I would rather think about, as we move further, what are some of the big picture things that we can use our December meeting for, so that we're not just thinking about reacting to the H1N1. And I think we've got some things articulated by Dr. Lurie, in terms of really looking at how -- what's our overall progress on integrating behavioral health into the overall HHS Public Health Emergency Response.

CHAIR QUINLISK: And Dan, I think you guys have done a good job. But let me -- maybe if I could give you an example, it might, at least from what I'm thinking of, might make it more understandable, I think, what we're asking for.

Under one of your actionable steps, you say HHS should identify and disseminate pertinent Behavioral Health materials that are relevant. Okay. To me, that's difficult to implement. If I were to get that, for example, HHS tell me to do that, that's very

difficult for me to implement.

What I think we're asking for is, we want HHS to send every state health department in the country this specific health information, and this information should be provided to every doctor in the state, to do X with their patients. That's, I think, what we're asking for.

Your actionable steps, I think are good. I think they're just a little bit hard to actually implement, because they're just not -- I don't know what pertinent behavioral health materials that you're talking about. And I don't know what disseminate means, to whom, how? And I think that's what we're trying to get to.

DR. GRABENSTEIN: Patty, this is John.

CHAIR QUINLISK: Dan, is there something you and Betty feel you could do? And if you could come up with some of those very specific things that we could pull out of

this, and say here is the exact action we want to be taken now. Do you think that that's feasible?

DR. DODGEN: Yes, I think in some of these, perhaps the best solution is to go back to the steps, the concrete steps that have been taken. For example, we pulled together a -- you know, what Dr. Lurie talked about, and what I talked about earlier, that we pulled together all the websites that we've given to Public Affairs. Actually, Gretchen, who may or may not still be on the line, her office actually has all of the websites, which cover children, special needs populations, general adult, as well as grief issues, in very specific ways, guidances, so I do think that some of those things have been done. So it sounds like maybe what would be beneficial to the Board is just having, perhaps seeing in writing, an articulation of the steps that have been taken concretely to implement some of these recommendations by my team, because

it sounds like that's what you're looking for. And I think some of that has already been done, so it sounds like we need to convey that information to the Board, and perhaps we can do it in writing as a way to make it easier for you to see, and to --

CHAIR QUINLISK: Dan, I guess I'm not asking for you to tell us what you've already done. I would like -- and this is not to sure-step, Dan. I want the Subcommittee -- I'd like them to say look, we are seeing that grief counseling is not being done. That is a high priority; therefore, we want this specific tool to be sent to every school in the United States for them to use during grief counseling when one of their children in their school dies. That's the specific thing I want. And I'm speaking for me, personally, so I do want to have the rest of the Board -- but I think just saying well, we've already put together information. It's on our website, is not very useful in the midst of an emergency.

I guess I need the Subcommittee's help in identifying what are the highest priority steps that we need to be taking in the next two weeks.

DR. PFEFFERBAUM: Dan, this is Betty. I think we can get a couple of people together, and identify these materials. And I guess, Patty, one question is, do you want us to actually provide materials, or are references to materials adequate?

CHAIR QUINLISK: Well, I think you need to say here is what we think is the best tool for this action that we're asking you to take, rather than just say we put a lot of stuff on this general website.

DR. PFEFFERBAUM: Oh, no. I agree and I think -- we will have difficulty selecting a single best tool, but we could give a list of a couple.

CHAIR QUINLISK: Okay. I think that's fine.

DR. PFEFFERBAUM: And like

reference for those, and I think we can do that, Dan. I can work with you, and I think we can get a couple of other people to just -- to give us a consensus on what this would be.

DR. DODGEN: Thanks, Betty. I appreciate that. And I agree, I think it's very -- I think that that's very doable. I just want to avoid us getting into a pattern where we're sort of always behind the curve, and that we're forgetting some of the proactive activities that we want to be doing. And I don't want us to be strictly in a reactive mode.

But having said that, I think that the request you're making, and Betty's suggestion is a way to address it, and makes a lot of sense.

CHAIR QUINLISK: Okay. Well, thank you, Dan. Let me open up to Board questions and we do need to have a public comment period, so Board, do you have any other thoughts on this?

DR. GRABENSTEIN: Yes, this is John Grabenstein.

CHAIR QUINLISK: Is everybody sort of in agreement in what was said, and how we're planning to progress at this point?

DR. GRABENSTEIN: Patty, this is John. I think this is a case where the Federal Department of Health and Human Services should view people like you as their customer, and you're the voice of the customer asking for something you need and having -- it's up to Uncle Sam to come through.

DR. SCHONFELD: Can I add one thing? This is David Schonfeld from the Mental Health Committee.

CHAIR QUINLISK: Go ahead.

DR. SCHONFELD: At my presentation, I talked about materials being available. And I did hear from the group that you wanted that access quickly, and I'm hearing that now. So, I actually went back, and the American Academy of Pediatrics has already created a separate

page on their Disaster Website around emotional adjustment to disasters, which lists those specific items that I said were available. And that link is available now. So, that just came out last week. So, there has been some specific progress, so the question is then how to share that at a national level.

CHAIR QUINLISK: Right.

DR. PFEFFERBAUM: I think that's the kind of thing Dan was suggesting that maybe we include in this next piece of correspondence to the Board.

CHAIR QUINLISK: Right. And just remember that this needs to be recommendations to HHS for what they then get out. But I appreciate you all, and I don't want to just keep on saying do more, do more, because I totally agree with Dan's concerns about meeting in December and looking at future issues. But I think right now, if we could get something very practical out, I think it would

be very, very helpful to us, especially with your expertise on understanding what are the priorities to be done in this area.

Leigh, let's go ahead. I know we need to have the public comment period. Can we go ahead and do that?

CAPT. SAWYER: Operator, will you please ask if there are public comments.

OPERATOR: At this time, if you would like to ask a question, please press *1 on your telephone key pad. Your first question comes from the line of Paul Gordon.

MR. GORDON: Yes. This is Paul Gordon. I'm out in the San Francisco Bay area here. I had asked a question before, and I guess I'd just like to express a few comments here.

I've heard a lot of commentary about managing public perception and information. I just heard a recent comment about grief counseling, and, also, specifically, Commissioner Cooper talk about

the number of hospitalized children at an all-time high, and half of these, of course, with H1N1, who are sick.

The issue I'd like to bring up is, in the management and the communication of this whole pandemic, what we do have happening is an unprecedented number of young people that are making it into intensive care, and that are actually dying. And this is part of the challenge that our government has in managing this whole crisis. And one of the things that has to be addressed is, in fact, how do you manage the poor folks from old people, down to children, that make it into intensive care? There isn't a day that goes by that we don't read about, today I can just do a Google search about ICUs being overwhelmed with acute influenza and they don't have the resources and acute shortage of respirators. So, this brings up a question which I had asked before, and I believe it dovetails into most of what has been brought

up today, which is making available all of the available tools and resources to address this.

And one of the things from a communication standpoint is, our country needs, and the world needs a different form of treatment for the people that do, in fact, make it into intensive care. And today, there are only two forms of antiviral treatments, that's Relenza and Tamiflu. And they have their role. The problem is, it doesn't do somebody that is on their back, and on a ventilator any good, because there's really no meaningful way to administer it.

There is a product called Peramivir, that's been through Phase III trials in Japan. And, as a matter of fact, Secretary Sebelius has made a declaration, presumably to set the stage for an emergency use authorization of Peramivir. I don't like to know what the status of that is. And probably, even more importantly, when we talk about trying to manage our resources, which

are limited at all fronts, is why isn't the availability, and the information about Peramivir available and published on the CDC website, when, in fact, it is available to attending physicians today through the use of an IND, and has already saved, to my knowledge, multiple individuals' lives. So, when we talk about managing, again, the public perception of what's happening, and we've got kids dying, this is something that could save the very people that we're talking about giving grief counseling to in the first place. So, I'd like to hear somebody please address, I guess, the real status of Peramivir and what we can do to bring this to the forefront here.

Somebody said what can we do over the next two weeks? I think as we have children dying, this is something that needs to be done over the next 24 hours.

CAPT. SAWYER: Is Aubrey Miller on the line from FDA?

DR. MILLER: Yes, I am here.

Peramivir is one of the -- we can't comment on something under review. Peramivir is being reviewed, along with other antivirals for IV usage. And there should be information, or decisions being made fairly soon. So, that, amongst other medical countermeasures are being currently evaluated by the Agency.

MR. GORDON: Do we have a time frame for when we can expect to see some response from the Agency?

DR. MILLER: Don't have a time frame for you, because it's under -- things are under review, so I don't have a specific time frame at this time.

MR. GORDON: Well, the comment I would just like to leave the whole group with, and let me first of all say my hat's off to all the public officials. This is an unprecedented task.

CAPT. SAWYER: Operator, we're ready for the next question.

OPERATOR: Your next question comes

from the line of Deborah Robinson.

DR. ROBINSON: Yes. My comment relates to the rumors, myths, and unwarranted fears in relation to thimerosal and the multi-dose vials of the H1N1 vaccine. I heard someone on television, a medical officer, someone compare the amount of mercury in thimerosal to mercury in canned tuna. And there was less. And I think if this is true, this is something people can really relate to. And it would be very helpful for that kind of message to get out to allay the fears of people taking the vaccine, especially in the multi-dose vials. And it's definitely information, everybody eats tuna fish and canned tuna. And I think this is something very concrete that people could relate to, and it could address some of these issues. Thank you.

CAPT. SAWYER: Aubrey, are you able to respond to that?

DR. MILLER: Yes, I don't have

specific information, but I can find out more with respect to Thimerosal. I'm not aware of Thimerosal being incorporated, but I can check with our vaccine division. I'm not sure if anybody's on from CBER at this time. Doesn't appear to be, so we can provide additional follow-up information. I don't have specifics on Thimerosal usage or communications, at this point.

CHAIR QUINLISK: This is Patty. I'll just say that one of the differences, too, is the difference between ethyl and methyl mercury. And that's not made very clear. But, let's go on to the next comment.

OPERATOR: Your next question comes from the line of Robert Reyl.

MR. REYL: Hello. I'm just a concerned parent. I'm down here in Texas, and I've just come from my doctor's appointment today. They've been out of seasonal flu vaccine for three weeks. They don't see getting any in, and they don't have the H1N1

vaccine yet. And I've been reading all these stories on the internet about these poor children in the hospital, in ICUs. I just read an article just a little bit ago about a 12-year old girl in Zionsville, Indiana that died. And this is a follow-up to Paul's question on Peramivir. To me, it's unacceptable that the FDA cannot comment on this. We've got all kinds of comments on the swine flu vaccine over the last few months. Peramivir has been working -- BioCryst has been working with the FDA since April on this. I don't understand what the holdup is. There should be some kind of a public announcement made on this of what the hold up is, and let the general public know.

CHAIR QUINLISK: Thank you for your comments. Let me just ask, Leigh, how long over our time do we need to go? How many public comments do we have left?

CAPT. SAWYER: Patty, that is the last public comment. I did receive an email,

a public comment from Michael Murphy, who's the editor of the New World Investor. And his comment we will make public as part of the summary of the meeting. It actually has been reflected in a series of comments on Peramivir, and, essentially, the concern about the FDA approved Emergency IND for Peramivir. So, I hope that people know about the availability of this drug for use under Emergency IND. This comment will be made publicly available. I think we've had a lot of discussion on this particular point, so I won't review it at this time.

CHAIR QUINLISK: Okay. Thank you. And I appreciate everybody's patience with having run over. Leigh, could you just remind us when the next conference call is?

CAPT. SAWYER: The next conference call is planned for November 13th. That's a Friday, from 12 to 2 p.m. All of the information for that teleconference will be posted on our website.

CHAIR QUINLISK: Okay. And I think then, unless we have any other urgent comment, we will go ahead and wrap up this meeting. Again, thank you, Leigh, to you and your staff, and particularly Dan, and the Mental Health Subcommittee for all the work that they've done. I appreciate that.

I'll stop for just a second. Are there comments? Okay. Then, I will just thank everybody for being here today, and appreciate everybody's tolerance with running over. Thank you very much.

(Whereupon, the above-entitled matter went off the record at 2:12 p.m.)