

Congenital Heart Public Health Consortium Steering Committee Meeting Minutes

November 22-23, 2009
Hilton Doubletree Atlanta - Buckhead
Atlanta, GA

PARTICIPANTS:

Geoffrey Rosenthal, MD, PhD, FAAP, co-chairperson
American Academy of Pediatrics (AAP)
Catherine Webb, MD, FAAP, co-chairperson
American Heart Association (AHA)
Craig Broberg, MD, FAAC
Alliance for Adult Research in Congenital Heart Disease (AARC)
Marcia Feldkamp, PhD, PA
National Birth Defects Prevention Network (NBDPN)
Shannon Hamrick, MD, FAAP
March of Dimes (MOD)
Jonathon Kaltman, MD (part-time, via telephone)
National Heart, Lung and Blood Institute (NHLBI)
Jodi Lemacks
National Congenital Heart Coalition (NCHC)
Amy Verstappen
Adult Congenital Heart Association (ACHA)
Robert Vincent, MD, FAAC
American College of Cardiology (ACC)

American Academy of Pediatrics

Lynn Colgrove, MBA
Manager, Section on Cardiology & Cardiac Surgery
Mark DelMonte, JD
Assistant Director, Department of Federal Affairs
Michelle Esquivel, MPH
Director, Division of Children with Special Needs
Vida U. Schwartz, MS
Project Consultant

Centers for Disease Control & Prevention (CDC)/

National Center on Birth Defects and Developmental Disabilities

Tiffany Colarusso, MD, MSE, FAAP
Medical Officer
Adolfo Correa, MD, PhD, FAAP
Supervisory Medical Officer
Cynthia Moore, MD, PhD
Associate Director of Science
Brenda Silverman, PhD
Public Health Analyst

Coleen Boyle, PhD, MSHyg (part-time)
Director, Division of Birth Defects and Developmental Disabilities
Amy Cordero, MPA
Management & Program Analyst
Margaret Honein, PhD, MPH (part-time)
Branch Chief, Birth Defects Branch

WELCOME

The first official in-person meeting of the Congenital Heart Public Health Consortium (CHPHC) Steering Committee convened on November 22, 2009 in Atlanta, GA. Drs Rosenthal and Webb, co-chairpersons of the CHPHC, welcomed attendees and thanked them for their time and efforts in preparing for and attending this meeting.

ROLES OF THE AAP AND CDC

Ms Esquivel provided a brief overview of the new five year AAP/CDC cooperative agreement, *Program to Enhance the Health and Development of Infants and Children*. The scope of this agreement includes a focus on modifiable birth defects, such as congenital heart defects, as well as early hearing detection and intervention, fetal alcohol syndrome and newborn screening.

As part of this cooperative agreement, as of September 1, 2009, the AAP has assumed central coordinating efforts of activities related to the CHPHC as well as its Steering Committee. The CDC will serve as technical advisors to the consortium going forward.

DISCLOSURES

Representatives from participating organizations introduced themselves and were requested to disclose any real or potential conflicts of interest. One member disclosed relationships with industry related to ongoing research; this will be noted in the meeting files. No other real or potential conflicts of interest were identified at this time. AAP staff requested that potential conflict of interest issues be kept at the forefront of all participants' minds as discussions and consortium work evolves.

CONSORTIUM HISTORY/GOALS

To ensure that all meeting participants had a common understanding of the activities which led to the development of the CHPHC, a brief overview of the evolution was provided.

A 2008 "meeting of experts", sponsored by the Centers for Disease Control and Prevention, was convened to generate new ideas for developing and advancing a public health approach to congenital heart disease(CHD). Approximately 50 attendees (representing academicians, researchers, clinicians, non-profit organizations, federal agencies, parent groups, etc) participated in plenary and break-out sessions to discuss important issues surrounding CHD. This meeting cultivated a common ground and provided momentum for the eventual establishment of the Congenital Heart Public Health Consortium (CHPHC).

Four public health priorities evolved from these initial discussions:

- increasing national awareness
- enhancing surveillance throughout the lifespan
- engaging in primary and secondary prevention research
- translation of research and data into interventions and policy

This group of experts agreed that a CHD consortium centered around these four public health strategies/priorities could influence six critical changes at the national level:

- improved CHD awareness, knowledge, skills, decisions
- early CHD diagnosis and treatment
- improved datasets for collaborative research
- improved understanding of CHD risk factors
- increased access to quality CHD healthcare and services across the lifespan
- sustainability for CHD public health action

A steering committee to lead this effort was convened and conference calls were held over the subsequent 12 months. A shared vision and mission statement was created and committee members began building a framework for future activities .

MISSION/VISION

The previously approved CHPHC mission and vision were shared with the attendees.

Mission

The consortium is a group of organizations uniting resources and efforts in public health activities. Our mission is to prevent the occurrence of congenital heart disease (CHD) and to enhance and prolong the lives of those with CHD through surveillance, population-based research, education, health promotion, advocacy, and policy development.

Vision

To be an effective national leader and facilitator for improvement in health outcomes of individuals with congenital heart disease.

CURRENT MEETING GOALS:

It was noted that the main purpose of the November 2009 Steering Committee was to build a road map to unfold the CHPHC based on the following goals:

GOAL 1: define strategic outcomes for Year 1

GOAL 2: define measurable objectives for Year 1

GOAL 3: develop strategies for achieving Year 1 objectives

ACTION: Dr Colarusso will send AAP staff the 2008 CHD meeting attendee/invitee list and other materials related to same.

ACTION: AAP staff will draft a letter from Drs Webb and Rosenthal to be sent to the 2008 potential consortium meeting participants to update, inform and re-engage their participation in the CHPHC, as well as to elicit participation from other interested parties.

GOVERNANCE AND BYLAWS

A proposed Steering Committee and organizational structure for the consortium was shared (Attachment A). The need for basic bylaws was identified. Steering Committee members and staff agreed that bylaws that would prevent potential future confusion related to the consortium's work and would offer clarity on scope and direction for the work going forward are necessary. Dr Webb recently participated in the writing of bylaws for another group with which she is involved and, as such, volunteered to lead this effort for the consortium.

ACTION: Drs Webb, Rosenthal and Mr Del Monte will draft CHPHC bylaws in the first quarter of 2010. These will be shared with Steering Committee members for review and potential approval.

CHPHC COMMUNICATION

The Steering Committee discussed the need for internal and external modes of communication and information sharing. As co-chairpersons of the CHPHC, Drs Webb and Rosenthal will serve as the hub of communication.

Conference Calls/Meeting: The need for regular "check-in" calls of the Steering Committee was noted; it was suggested that these conference calls also would provide opportunities for reporting subcommittee work. A potential fall 2010 Steering Committee meeting also was discussed.

Web Site/Page: A web site/page consisting of 1) a public area to include information and resources about CHD as well as the consortium and 2) a restricted area for information sharing amongst CHPHC and its Steering Committee was discussed. It was noted that such a web site/page could be developed as a stand-alone or included on the AAP/National Center for Medical Home Implementation web site.

Listsers: Listserv for the Steering Committee and the larger CHPHC membership will also serve as an effective mode for communication going forward. Select members of each participating organization could be on the listserv and then be responsible for disseminating information to their respective organizations.

ACTION: With guidance from Dr Webb, AAP staff will begin to 1) create a basic format and structure for a CHPHC web site and; 2) gather materials and resources to be included on the site.

ACTIONS: AAP staff will

- develop a Steering Committee conference call schedule (the first call to occur after January 2010 and subsequent calls every two months).
- poll the Steering Committee in early 2010 regarding a potential date for a fall 2010 Steering Committee meeting.

- establish a Steering Committee listserv by January 2010.
- identify one representative from each participating CHPHC organization to participate in the consortium listserv; Steering Committee members also will be included on the consortium listserv.

CONGENITAL HEART FUTURES ACT

Ms Verstappen provided an overview of the history and current status of the Congenital Heart Futures Act (CHFA). She reported that in 2005 the American Congenital Heart Association (ACHA) partnered with the American College of Cardiology (ACC) to hold the first national lobby day exclusively focused on the life-long needs of the congenital heart community. Eighty participants secured budget report language calling for funding for health education and research in the area of congenital heart disease. In 2008, the National Congenital Heart Lobby Day was endorsed by member organizations of the National Congenital Heart Coalition. That same year, the National Heart, Lung and Blood Institute (NHLBI) convened a working group on CHD, which recommended the following:

- developing a research network to conduct clinical research
- establishing a national database of patients
- creating an outreach education program for continued/lifespan cardiac care needs

In turn, the CHFA builds upon these NHLBI recommendations by authorizing the Secretary to:

- increase surveillance
- increase research
- promote awareness (see Attachment B)

In 2006, nearly 150 advocates joined efforts to encourage senators and legislators to support this groundbreaking legislation to benefit CHD patients and their families. In March 2009, the CHFA was introduced by Senator Richard Durbin (D-IL). The bill currently has 5 co-sponsors in the Senate and 33 co-sponsors in the House. The next step is to hold hearings in the committees of jurisdiction.

PRIORITIZING AND SELECTING ACTIVITIES/PROJECTS

The Steering Committee, over the past year, decided that the six areas of long-term change identified from the initial meeting of experts were key goals for the CHPHC. Prior to the November 2009 meeting, Steering Committee members were assigned to begin developing possible action steps focused on furthering work on each of these long term goals. Six presentations were provided at the November 2009 meeting to enhance discussion and decision making regarding the direction/activities that the consortium should engage in over the short and long term.

Improved CHD awareness, knowledge, skills, decisions

On behalf of the AARC and ACHA, Dr Broberg presented recommended activities focused on improving national CHD awareness, knowledge, skills and decisions. Three separate target audiences were identified including the following:

- Public (Ideas for reaching this audience were shared with an emphasis on a high profile media campaign and other media relation activities including the development and promulgation of news releases, when relevant).
- Patients/families (Ideas for reaching this audience included the development of educational resources.)
- Providers (Ideas for reaching pediatricians, other pediatric and adult primary care providers, and adult and pediatric cardiologists through the development of educational resources such as symposia and publications were suggested).

In terms of provider education, the Steering Committee noted the importance of sharing CHD resources, knowledge and skills with non-cardiologists. Focused education and information through existing society meetings, symposia, development of training modules, monthly newsletters, magazines, and other communications was discussed.

In terms of public awareness/education, a media feasibility study was suggested. Details on how to operationalize this activity were briefly considered. It was noted that if pursued, focus should be on one small geographic area before expanding this activity. Promoting CHD as one component of National Birth Defects Prevention month (January) could also be a fruitful way to promote public awareness.

The following additional ideas were suggested in the context of this discussion:

- collaborating with the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) on provider education/awareness activities
- developing editorials and non-research oriented articles for publication in lay press and/or scientific journals
- creating messaging (or disseminating current messages) around CHD to key partners and the public in conjunction with National Birth Defects Prevention month (January)

It was noted that – to the extent possible – a strategic plan with *measurable outcomes* will be necessary.

ACTION: AAP staff will work with Steering Committee members to develop consistent and concise messaging on CHD for National Birth Defects Prevention month in January 2010.

Early CHD diagnosis and treatment

Presenting on behalf of the ACPC of the American College of Cardiology and the March of Dimes, Dr Vincent outlined potential tasks that the consortium could undertake to help improve early diagnosis and treatment of CHD. It was proposed that identifying those at risk (family history, previous child with CHD, family history of unexplained death

and syndromic patients) and targeting a specific population (prenatal, newborn, pediatric, known CHD patient, those with signs and symptoms) should be prioritized in terms of addressing early diagnosis and treatment. The following are highlights from this presentation and the subsequent discussion:

- Currently, prenatal evaluation is imprecise in that it only *identifies* major structural issues at best; evaluating everyone is not realistic; level 1 ultrasound evaluation is questionably adequate; and evaluating solely those at risk will miss those without a previous history.
- Recent data indicate that routine pulse oximetry performed on asymptomatic newborns, before discharge **may** detect CHD. Routine pulse oximetry performed after 24 hours in hospitals that have on-site pediatric cardiovascular services incurs very low cost and risk of harm. But cost-effectiveness is still questionable. Studies in larger populations across a broad range of delivery systems are needed to determine whether pulse oximetry should become a routine standard of care in the assessment of a newborn.
- Newborn physical examination is not and will never be 100% sensitive.
- In terms of *treatment* – anatomic and physiologic treatments are more tangible and, in turn, easier to relate to as they are clearly clinical and surgical. Cognitive, developmental and behavioral treatments to CHD related issues are more challenging to describe and address especially when patients are entering society and the adult world.
- It is not a current standard of care to scan for or address non-cardiac issues when a cardiac diagnosis is made, though there are more than just clinical cardiac disease diagnoses that affect these children. Cognitive, developmental and behavioral treatments are often just as crucial for CHD patients. Several organizations are interested in cognitive issues and education. Assessment of these secondary issues should be a routine part of screening and care.
- Outcomes data are currently limited. Society of Thoracic Surgeons data (referred to as STS data) are limited. American College of Cardiology and National Cardiac Data Registry data – known as Improving Pediatric and Adult Congenital Treatment (IMPACT) registries – are a good start; however, these are in the preliminary stages of development and focused on identifying the surgeons' clinical success, and do not necessarily address overall patient outcomes. Without longitudinal follow up and neurodevelopmental assessment, it will be difficult to assess and determine future steps.
- A unique patient identifier is necessary for longitudinal studies. This is a major need, yet point of contention. It is very difficult – if not impossible – to recommend “good therapy” when there are no known long term outcomes data.

- Ideally, a combination of screening methodologies should be used to overcome limitations of individual techniques. Before deciding those methodologies, many questions need to be answered including, but not limited to, the following: how often does a screen fail; what is the impact on the patient; what is the morbidity and mortality of delayed diagnosis; and what issues could be picked up after 24 hour discharge through 4 months of age or more.
- It was noted that as screening for CHD is a somewhat controversial topic due to varying opinions and lack of clear data/science, the CHPHC public health approach may prove to be effective in elucidating these issues and progressing in this area.

Recommendations for potential CHPHC work in the area of early diagnosis and treatment of CHD included the following:

- define risk categories that could be screened based on existing data
- identify, describe and define current registries and databases
- decide on whether a meeting of the data collecting groups (STS, IMPACT, etc) would be advantageous. It was suggested that a meeting held in conjunction with (the day before) a subsequent 2010 CHPHC Steering Committee meeting may be fruitful.
- if a meeting of the various groups currently collecting CHD data is held, the information gathered will be reported back to the Steering Committee members. The Steering Committee will assess and decide next possible steps, if warranted.

Improved datasets for collaborative research

Dr Feldkamp, National Birth Defects Prevention Network, outlined ways for the CHPHC to improve national datasets as a means to enhance collaborative research. National prevalence data is limited due to differences in or lack of surveillance data. As discussed previously, an ideal long term goal would be to develop a national registry for CHD that is population-, clinic- and hospital- based. The need to determine existing registries and identify potential collaboration or data access, encourage data sharing/linking, and support efforts to create CHD ontologies and data dictionaries was reiterated.

Highlights from this presentation/discussion include the following:

- There are numerous existing resources that the CHPCH could review and assess to further its work in this area (for example, in Europe work on data standardization is already underway).
- The NBDPN facilitates each state having its own data base, therefore each may function very differently in regard to data acquisition. Also, collectively the data are not accessible and database(s) are not linkable.
- The National Birth Defects Prevention Study is a population-based study conducted in 8 states to identify environmental and genetic risk factors for major birth defects including congenital heart defects.
- The NBDPN has a standards and guidelines manual from which the CHPCH could begin work.

- Additional resources are needed to advance the necessary “pre-work” that must be accomplished prior to taking on the CHPHC broader goals in this area. These include:
 - development of specific definitions/determinations for a given population
 - funding for states to obtain accurate/pre-determined data
 - development of a data dictionary
 - development of a relational database
 - rules regarding “ownership” of data, storage of data, access to data, and HIPAA as it relates to progressing or limiting data sharing

To begin this work, Dr Feldkamp suggested that a research subcommittee be formed under the auspices of the CHPHC. This subcommittee would attempt to identify existing registries; creating a list of existing registries and identifying the potential for collaboration and data access; encouraging data sharing/linking between organizations; supporting groups interested in data standardization; and advocating that current and new registries adopt standard terminology. This committee could also outline what is needed for a national registry, given the importance of population-based surveillance.

Advocacy and education related to the need for a national CHD registry and a micro-detailed plan for the development of a national registry may be optimal. Conceptually, this type of registry is ideal; however, great efforts and time to change and/or work around the current rules and regulations that limit this type of data collection and communication will be needed before advancements can be made.

Improved understanding of CHD risk factors

Drs Correa and Colarusso discussed potential ways the CHPHC could work to improve national understanding of CHD risk factors. In 2007 a notable scientific statement from the AHA, *Non-Inherited Risk Factors and Congenital Cardiovascular Defects: Current Knowledge* was published.

A *Scientific Statement* from the American Heart Association Council on Cardiovascular Disease in the Young, endorsed by the American Academy of Pediatrics, was published in *Circulation* (online May 22, 2007; <http://circ.ahajournals.org>).

Though critical challenges in comparing existing studies of CHD risk factors include non-standardization of case ascertainment, nomenclature and classification of CHD, this 2007 scientific statement pulls together non-inherited CHD risk factors. The Metropolitan Atlanta Congenital Defects Program (MACDP) recently improved their CHD dataset using standard nomenclature of the STS, and supports better ascertainment and classification in other states. However, improvements in standardization take effort and resource allocation.

Though there are numerous individual studies, it would be worthwhile to pool and organize the efforts of the various groups and organizations working toward improved health outcomes for those with CHD. While there are several international cohort studies for pooling efforts, again standardization is needed. Standardization of

verbiage, definitions, data collection and priorities is an initial crucial step toward success.

The following CHPHC activities related to improving the understanding of CHD risk factors were suggested:

- creation of an internet-based repository of resources on known modifiable risk factors (articles, meeting presentations, resources, etc)
- creation of a master calendar of upcoming meetings, conferences, events to improve communication and interaction with interested groups/organizations
- sponsorship of workshops/sessions on CHD risk factors or public health aspects of CHD at identified meetings
- collaboration on potential research activities related to CHD risk factors

The following specific goals were prioritized:

- support for better ascertainment and classification in various states
- mapping codes and classification in NBDPS to STS nomenclature used in the MACDP

Ms Colgrove noted that the AAP Section on Cardiology has a web page on the AAP Web site that the CHPHC may find informative.

With links to many professional organizations, the CHPHC Steering Committee members will work to identify opportunities to further educate target audiences regarding key CHD risk factors.

Increased access to quality CHD healthcare and services across the lifespan

Ms Verstappen and Ms Lemacks provided an overview regarding the need for increased access to quality CHD healthcare services across the lifespan. They noted that historically the focus has been on primary prevention (genetics and causation) yet now the focus also needs to be on secondary prevention (improving outcomes and avoiding secondary conditions for the large number of [1.8 million] CHD survivors). It was noted that CHD patients are living longer – with an improved quality of life – there is an increased loss to follow-up. Further, many patients are feeling well and are non-symptomatic, though they remain at high risk and should remain in continuing care. A recent Canadian study indicated that most children who have CHD stop seeing their cardiologist by 13 years of age. Information and data currently available support the need for studies, follow up and assessment of this new group of chronically ill children with CHD and a new group of adult CHD survivors.

It was suggested that the aim for the consortium regarding access to quality healthcare and services should be two-tiered with focus on the following:

- Better care with improved outcomes
 - attain better data across the lifespan
 - standardize data
 - collaboratively data share

- Additional research and policy
 - insurability
 - preferential payment for quality care
 - coding
 - eliminating lifetime capitation
 - eliminating pre-existing conditions

To accomplish these goals, organizations must collaborate on the development of an agreed upon, standardized, detailed approach to data collection which would lead to improved research, outcomes and policy and ultimately better care.

Suggested initial action steps for the consortium include:

- potentially cultivating the development of adult CHD sub-specialty/credentialing
- preparing a statement that recommends all CHD centers to identify plans for providing life long care
- formally respond to the goals/objectives for Healthy People 2020, which is currently in the public comment phase

Sustainability for CHD public health action

Mr Del Monte presented strategies to increase support for CHD-related policies. He noted two primary goals for same including a) raising awareness among public policy makers of the prevalence of CHD and its impact across the lifespan and b) increasing federal resources devoted to CHD prevention, screening and lifelong care, respectively.

It was noted that organizations represented in the CHPHC could:

- identify existing advocacy efforts occurring within their respective organizations and share information about these resources, events and activities
- coordinate advocacy activities with existing events to maximize participation and impact
- catalogue and disseminate available information on federal resources devoted to CHD
- organize a Capitol Hill briefing for lawmakers on CHD

SUMMARY AND CONCLUSIONS

Subsequent to the six presentations of proposed CHPHC goals/objectives, it was determined that despite some minor challenges and interests, the recommendations from Steering Committee members toward accomplishing various objectives coincided. Essentially, the presentations and discussions proposed two types of action: information gathering and information dissemination. Extensive discussion ensued focused on identifying projects that were small enough to attain success, yet dynamic enough to generate attention among CHPHC stakeholders. The Steering Committee agreed that the initial activities should focus on areas that the organizations represented on the CHPHC could coalesce and successfully accomplish together.

The committee agreed that the following information **gathering** should occur over the next year:

- dataset landscaping, in preparation for a meeting of the data “owners” in fall 2010
- promotion of prevention and risk factors
- screening information gathering
- cataloguing of federal resources spent on CHD
- defining media resources, messaging, explore opportunities for key message dissemination
- developing a web page for CHPHC (including information on data, resources on risk factors, and a meeting calendar)

The committee agreed that the following **dissemination** should occur over the next year:

- explore opportunities for information sharing/dissemination (letters-to-the-editor, web site, etc)
- formulate basic CHD descriptive information sheets
- develop commentary on types of screening and issues surrounding same which have been published to date
- construct a one page overview for lawmakers and the public on CHD
- develop media messages (targeting specific populations, geographic locales)
- submit abstracts/program proposals for consideration to national conference of practitioners (ACOG, AAFP, etc) regarding the issues related to public health risk factors and CHD

CHPHC STEERING COMMITTEE SUBCOMMITTEES

Subcommittees were formed, tentative chairpersons identified, and action items generated, as follows, to accomplish goals and objectives that were developed. One of the CHPHC co-chairpersons (Webb or Rosenthal) will serve on each subcommittee initially to maintain the flow of information and assist in development. Members of the Steering Committee will serve as subcommittee chairs until the subcommittee is developed and perhaps another person voted subcommittee chair. The Steering Committee representative on each of the subcommittees will report the progress of the subcommittee to the Steering Committee.

Webpage Subcommittee (Dr Webb and AAP staff):

ACTION: Dr Webb will identify and invite at-large consortium members to participate on the **webpage subcommittee**.

ACTION: Dr Webb, AAP staff and the **webpage subcommittee** will organize and manage the CHPHC web page development, maintenance and information gathering. It will include information on datasets, resources on risk factors, a meetings and events calendar, and other information as discussed.

ACTION: AAP staff will place the CHPHC Steering Committee conference call and meeting schedule on the CHPHC web site.

Dataset Subcommittee (Drs Vincent and Webb):

ACTION: Drs Vincent and Webb will identify and invite at-large consortium members to participate on the **dataset subcommittee**.

ACTIONS: Drs Vincent, Webb, and the **dataset subcommittee** will:

- develop a data set landscaping fact sheet.
- assist with the coordination/planning of a potential 2010 fall meeting of the data “owners.”

Prevention Subcommittee (Drs Correa and Rosenthal):

ACTION: Drs Correa and Rosenthal will identify and invite at-large consortium members to participate on the **prevention subcommittee**.

ACTIONS: Drs Correa, Rosenthal and the **prevention subcommittee** will:

- work to promote knowledge of prevention/risk factors.
- develop a fact sheet/overview of key issues and data related to prevention/risk factors.
- create an inventory of currently understood modifiable risk factors.
- discuss the effectiveness of interventions based on available data/science.

Screening Subcommittee (Drs Correa and Rosenthal):

ACTION: Drs Correa and Rosenthal will identify and invite at-large consortium members to participate on the **screening subcommittee**.

ACTION: Drs Correa, Rosenthal and the **screening subcommittee** will

- consider developing a concept paper to articulate issues surrounding screening options to maximizing the predictive value and treatment.

Federal Affairs Subcommittee (Drs Kaltman and Webb and Mr Del Monte):

ACTION: Drs Kaltman, Webb and Mr Del Monte will identify and invite at-large consortium members to participate on the **federal affairs subcommittee**.

ACTION: Drs Kaltman, Webb, Mr Del Monte and the **federal affairs subcommittee** will

- catalogue federal resources spent on CHD and how this compares to allocations for other chronic illnesses with similar disease burden.
- develop a CHD fact sheet/overview for policymakers.

Awareness Subcommittee (Dr Rosenthal, Ms Mitchell, and AAP staff):

ACTION: Dr Rosenthal will invite Ms Mitchell of the NCHC/AARC to help lead the **awareness subcommittee**.

ACTION: Dr Rosenthal will identify and invite at-large consortium members to participate on the **awareness subcommittee**.

ACTIONS: Dr Rosenthal and the **awareness subcommittee** will

- gather information on existing awareness campaigns and messaging related to CHD
- further define and identify the target audience.
- define potential messaging focused on several target audiences.
- create a draft marketing/communications plan and related timeline.
- identify other opportunities for public awareness on CHD public health issues.

ACTION: AAP staff will work with **awareness subcommittee** leaders/members to organize preliminary discussions regarding awareness goals/objectives.

ADJOURNMENT

The co-chairpersons thanked Steering Committee members for their participation and an extremely productive meeting which concluded with a clearly identified action plan for the next 12-18 months.

The meeting adjourned at 2:15pm EST.

Respectfully submitted,

Vida U. Schwartz, MS
Program Consultant

:vus

Att: