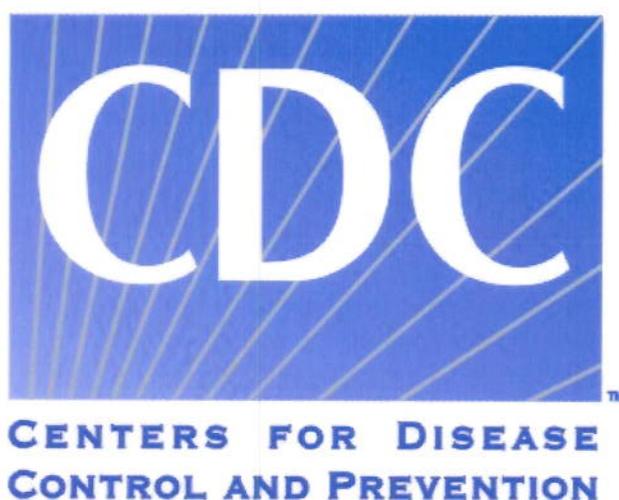


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
Coordinating Center for Health Information and Service
National Center for Health Marketing**



**Board of Scientific Counselors
June 5-6, 2008
Atlanta, Georgia**

FINAL Record of the Proceedings

TABLE OF CONTENTS

	<u>Page</u>
Attachment 1: List of Participants.....	A1.1
Attachment 2: Acronyms Used In These Meeting Minutes	A2.1
Meeting Minutes	1
June 5, 2008	
Opening Session.....	1
Overview of FACA.....	2
Overview of NCHM	5
Overview of the Division of Health Communication and Marketing.....	8
Overview of the Division of eHealth Marketing	9
Overview of the Division of Partnerships and Strategic Alliances	11
Overview of the Division of Creative Services	12
June 6, 2008	
Overview of the NCHM HCSOs.....	16
Overview of Pandemic Influenza Risk Communication.....	21
Public Comment Session	25
Open BSC Discussion.....	25
BSC Business Session	27
Closing Session	28

ATTACHMENT 1

List of Participants

BSC Members

Dr. Kasisomayajula Viswanath, Chair
Dr. David Ahern
Dr. Marilyn Aquirre-Molina
Dr. Richard Bagozzi
Dr. Diana Cassady
Dr. Barbara DeBuono
Dr. Sonya Grier
Ms. Donna Nichols
Dr. William Smith

Designated Federal Official

Dr. Kathleen McDuffie,
Executive Secretary

CDC Representatives

Dr. Steven Solomon, CCHIS Director
Dr. Jay Bernhardt, NCHM Director
Dr. Katherine Lyon-Daniel,
NCHM Deputy Director
Martha Alexander
Cynthia Baur
Diane Beistle
Anatavia Benson
Amy Burnett
Frank Ceo
David Clark
Joanne Cox
Carol Crawford
Dogan Eroglu

Joyce Essien
Fred Fridinger
Lawrence Furphy
Dawn Griffin
Walter Harris
Veronnica Hobbs
Josephine Jones
Kathy Kirkland
Cheryl Lackey
Mary Lerchen
Ronnie Lindsey
Steve Luce
Robert Martinez
Dionne Mason
Diane Mayham
Jeff McKenna
DeBrittany Mitchell
Devonne Mitchell
Jane Mitchko
John O'Connor
Cathy Ramadei
Jill Roark
George Roberts
Susan Robinson
Renee Ross
Kurt Schilling
Kimberly Smith
Lynn Sokler
Nadine Sunderland

ATTACHMENT 2

Acronyms Used In These Meeting Minutes

ADCSs	—	Associate Directors of Communication Sciences
ATSDR	—	Agency for Toxic Substances and Disease Registry
BSC	—	Board of Scientific Counselors
CCHIS	—	Coordinating Center for Health Information and Service
CDC	—	Centers for Disease Control and Prevention
COTPER	—	Coordinating Office of Terrorism Preparedness and Emergency Response
DCS	—	Division of Creative Services
DeHM	—	Division of eHealth Marketing
DFO	—	Designated Federal Official
DHCM	—	Division of Health Communication and Marketing
DPSA	—	Division of Partnerships and Strategic Alliances
FACA	—	Federal Advisory Committee Act
FTEs	—	Full-Time Equivalents
GHOM	—	Global Health Odyssey Museum
GSA	—	General Services Administration
HCSOs	—	Health Communication Science Offices
HHS	—	Department of Health and Human Services
KAB	—	Knowledge, Attitudes, Beliefs
K2A	—	Knowledge-to-Action
MASO	—	Management Analysis and Services Office
MCSB	—	Marketing and Communication Strategy Branch
NCHHSTP	—	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCHM	—	National Center for Health Marketing
NCIRD	—	National Center for Immunization and Respiratory Diseases
NHANES	—	National Health and Nutrition Examination Survey
OD	—	Office of the Director
PSAs	—	Public Service Announcements
SGEs	—	Special Government Employees

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**BOARD OF SCIENTIFIC COUNSELORS
June 5-6, 2008
Atlanta, Georgia**

FINAL Minutes of the Meeting

The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) Coordinating Center for Health Information and Service (CCHIS) National Center for Health Marketing (NCHM) convened the first meeting of the Board of Scientific Counselors (BSC). The proceedings were held on June 5-6, 2008 at the CDC Global Communications Center, Building 19, in Atlanta, Georgia.

Opening Session

Dr. Kasisomayajula Viswanath, Chair of the BSC, called the proceedings to order at 1:07 p.m. on June 5, 2008 and welcomed the attendees to the first NCHM BSC meeting. He thanked the BSC members for agreeing to participate in an exciting activity and taking advantage of a tremendous opportunity to provide external guidance and input to NCHM.

Dr. Viswanath explained that the BSC would be most helpful in advising NCHM on consolidating and refining its vision, mission, goals and organizational structure and on expanding and implementing its science. However, he clarified that the BSC's recommendations to NCHM should be constructive, realistic and feasible given the current environment of limited resources. He noted that the BSC also should consider strategies to advocate and make a strong case for additional resources for NCHM to accomplish its goals.

Dr. Viswanath pointed out that the BSC is a talented group of experts with diverse backgrounds and experience. However, workgroups could be established if the BSC saw a need to engage external consultants to address a specific topic. To further assist the BSC in fulfilling its charge to provide input to NCHM, Dr. Viswanath conveyed that the members would be asked to suggest presentations and overviews of specific topics to place on future agendas.

Dr. Kathleen McDuffie, Designated Federal Official (DFO) of the BSC, congratulated the members on being selected to serve from a larger pool of applicants. She explained that the

term limits of the BSC members were established for two, three and four years. The staggered approach would help to retain institutional memory by ensuring that the terms of the first cycle of BSC members would not expire at the same time.

Based on the biographical sketches of the members, Dr. McDuffie was pleased that the BSC met the Federal Advisory Committee Act (FACA) rule for a federal advisory committee to be diverse. She highlighted other key points of FACA. While serving on the BSC, the members are Special Government Employees (SGEs). All BSC meetings are open to the public and would be loosely operated under "Robert's Rules of Order" in terms of being respectful of each individual's opinion and being recognized by the Chair before speaking.

All of the BSC's recommendations would be consensus advice to NCHM and available to the public. NCHM would develop a web site in the future to post the BSC's membership, meeting minutes, consensus recommendations and other items. In her role as the DFO, Dr. McDuffie would ensure that all of the BSC's functions and actions adhere to its charter.

Dr. McDuffie thanked the BSC members for taking time from their busy schedules to provide valuable guidance and advice to NCHM. She was extremely pleased that the first BSC meeting represented 100% of the entire membership.

Dr. Jay Bernhardt, Director of NCHM, also thanked the BSC members for providing guidance and honest input to improve NCHM's effectiveness, impact and excellence in promoting public health. He particularly recognized Dr. Viswanath for accepting the responsibility and making a significant commitment to serve as the BSC Chair.

Dr. Bernhardt thanked the NCHM staff for making enormous efforts over the past year to plan and organize the first BSC meeting. He explained that the first meeting would be different than those in the future because extensive overviews of NCHM and its divisions would be presented as an "orientation." Future meetings would focus more on the BSC's feedback to NCHM and place less emphasis on presentations.

Dr. Viswanath opened the floor for introductions. None of the BSC members stated conflicts of interest with any of the items on the June 5-6, 2008 published agenda. The list of participants is appended to the minutes as [Attachment 1](#).

Overview of FACA

Ms. Renee Ross, of the CDC Management Analysis and Services Office (MASO), explained that FACA provides a legal foundation for establishing and managing all federal advisory committees. Congress created FACA with a number of guiding principles. New advisory committees are to be established only when these groups are determined to be essential. Advisory committees are to be formed to provide guidance that is relevant, objective, free of undue influence and open to the public.

Standards and uniform procedures must govern the establishment, operation, administration and duration of all advisory committees. All persons must have knowledge of the purpose, membership, activities and costs of advisory committees. Each advisory committee must be terminated after its purpose is fulfilled.

The General Services Administration (GSA) is responsible for FACA oversight, management and compliance. Agency heads establish uniform procedures and administrative guidelines for advisory committees and also designate Committee Management Officers to exercise control and supervision of establishment procedures and accomplishments of all advisory committee.

Federal advisory committees can be established by mandate or at the discretion of an agency. Mandated committees are authorized by statute or the President through an Executive Order. Discretionary committees are established when an agency determines the need for advice and recommendations from an advisory committee, consults with GSA, and provides notice to the public of its intent. CDC established the NCHM BSC as a discretionary committee.

The purpose of each advisory committee is determined and memorialized in its charter. The agency assigns a DFO to serve as the Executive Secretary, approve meeting agendas, ensure the publication of meetings in the *Federal Register*, and attend all meetings. The President or agency head appoints committee members and designates a chair.

The role of a federal advisory committee is to provide federal officials and the nation access to information and advice on a broad range of issues that affect federal policies and programs. Advisory committees allow the public to actively participate in the federal government decision-making process. The membership of an advisory committee must be fairly balanced to the fullest extent possible in terms of its function and points of view represented.

Advisory committees can be established with three categories of members. SGEs are private citizens who are appointed based on their expertise and are subject to the "Standards of Ethical Conduct for Employees of the Executive Branch." *Ex-officio* members are representatives of federal agencies who provide subject matter expertise on behalf of their respective agencies. Liaison members represent special interest groups, organizations or affected populations.

FACA outlines specific requirements for advisory committees to convene meetings. A notice announcing the meeting must be published in the *Federal Register* with a description of the purpose of the meeting and a summary of the agenda with the time, location and contact information. The notice must be published not less than 15 days prior to the meeting. The DFO must approve the agenda and attend all meetings.

Any member of the public must be given an opportunity to speak or file a written statement. Detailed minutes must be developed and made available to the public. Any official records generated by or for an advisory committee must be retained for its duration. The records will be transferred to the National Archives and Records Administration upon the termination of the advisory committee.

Advisory committees can form subcommittees or workgroups to perform special tasks. A subcommittee must be represented by at least one member of the parent committee and report directly to the parent committee. Although subcommittees are not subject to FACA, CDC policy requires compliance with these provisions. The parent committee must deliberate the subcommittee's recommendations.

Workgroups are formed to conduct research, gather information, and analyze issues and facts. Workgroups must be represented by at least two members of the parent committee or subcommittee and report directly to the parent committee or subcommittee. Workgroups are not subject to FACA and cannot formulate advice or recommendations.

After an advisory committee deliberates and votes on issues, the recommendations can be forwarded to the Director of CDC, Secretary of HHS, GSA, the President or Congress. Overall, FACA ensures that advice rendered to the Executive Branch by advisory committees, task forces, boards and commissions is objective and accessible to the public.

Ms. Cathy Ramadei, of MASO, informed the BSC of FACA requirements regarding financial disclosure and conflicts of interest: The Ethics Reform Act of 1989 requires SGEs to provide financial disclosure upon appointment and each year of their terms thereafter. Agencies use financial disclosure reports of SGEs to ensure that advice and recommendations are free from conflicts of interest.

Financial disclosure reports also allow agencies to determine appropriate actions to take if a conflict arises with an SGE. For purposes of the NCHM BSC, MASO, the DFO and the CDC Office of General Counsel review financial disclosure reports to identify any potential conflicts of interest or problematic issues with an SGE.

The primary conflict of interest statute prohibits SGEs from participating in any specific party matter that would specifically and directly affect their financial interests. The bribery statute prohibits SGEs from seeking or accepting any item of value in return for being influenced in relation to performing their official duties. Two representation statutes prohibit SGEs from receiving compensation for representing an individual or an issue before an agency in a particular matter involving specific parties where an SGE has acted in an official capacity.

The post-employment statute imposes a lifetime ban in which former SGEs cannot represent another individual or entity to the government in any matter involving a specific party if the SGE was involved in that matter as a federal advisory committee member. The foreign activities statute prohibits any SGE from receiving any present, emolument, office or title from a foreign state without the consent of Congress. SGEs cannot act as an agent or lobbyist on behalf of a foreign entity under the Foreign Agents Registration Act.

Ms. Ramadei informed the BSC members that Dr. McDuffie should serve as the first point of contact with any questions or concerns regarding potential conflicts of interest that might arise during their respective terms. She concluded the overview of FACA by presenting "The Ethical Choice" video.

Ms. Ross and Ms. Ramadei provided additional information on FACA in response to specific questions posed by the BSC members.

- The BSC's recommendations to the Director of CDC or the Secretary of HHS will be forwarded through CDC from the DFO and the Director of NCHM.
- BSC members can only provide information or give testimony to Congress as individuals or private citizens. The members cannot divulge matters that have not been discussed in a public forum or represent the BSC to Congress without authorization from CDC.
- The BSC can close a meeting and convene an executive session only under special circumstances, such as the need to discuss private and confidential matters or issues related to national security. The BSC would need to obtain approval from CDC in advance of closing a meeting.
- The BSC must have a quorum of six voting members who have no conflicts of interest to convene a meeting and vote on issues. During the introductions at the beginning of each meeting, the BSC members should state "no conflict," identify any conflict with the current agenda, or inform the BSC that a conflict of interest waiver was obtained.
- BSC members and all other SGEs can serve up to 130 days on a federal advisory committee within a 365-day period.

Overview of NCHM

Dr. Bernhardt explained that NCHM is housed in CCHIS and has an organizational structure of four divisions, seven teams and the Business Services Offices in the NCHM Office of the Director (OD), and ten Health Communication Science Offices (HCSOs). NCHM's current resources include ~550 full-time equivalents (FTEs) and contractors and an FY'08 budget of ~\$100 million.

NCHM OD is structured with a Business Services Office, Global Communication Team, Marketing Sciences Team, Policy Team, Preparedness (and Practice) Team, Science Team, and *Morbidity and Mortality Weekly Report* Team. CDC recently announced a new position for a Senior Advisor for Health Equity to be housed in NCHM OD. The goal of this new position will be to increase NCHM's emphasis and programmatic activities in the areas of health equity, health disparities and social determinants of health.

Because the first BSC meeting primarily would be devoted to overviews of NCHM's four divisions, Dr. Bernhardt confirmed that Team Leaders could make presentations on the functions and activities of NCHM OD during future meetings.

NCHM adapted the American Marketing Association's definition of "health marketing" as an organizational function and a set of scientific processes for creating, communicating and delivering value to customers and for managing customer relationships in ways that protect and promote the health of diverse populations. NCHM also defines "health marketing" as a multidisciplinary area of practice that is informed by health communication, social marketing, science and other related disciplines.

NCHM applies four categories of health marketing sciences to inform the development and implementation of its activities. "Communication sciences" include health, risk, visual, mass, interpersonal, organizational, public relations and computer-mediated communications. "Marketing sciences" include audience research, advertising and branding. "Behavioral and social sciences" include sociology, psychology and anthropology. "Health and public health sciences" include CDC's traditional public health mission and role.

The mission of NCHM is to protect and promote public health through collaborative and innovative health marketing programs, products and services that are customer-centered, science-based and high-impact. NCHM created seven value statements to guide its health marketing activities and establish a solid foundation for its relationship with staff.

Communication will be accessible, clear and candid. Programs will be scientific and ethical. Partnerships will be collaborative and engaging. Activities will be equitable and transparent. Actions will be caring and compassionate. Continuous improvement will be based on research. The workplace will be diverse, empowering and fun.

NCHM also reviewed the traditional commercial marketing model to obtain a basis for its health marketing activities. The components of this model include products and brands; a sales force, distributors and retailers; customers; market research, audience segmentation, sales and marketing metrics; and product development, packaging, placement and promotion.

In applying the commercial marketing model to health marketing, NCHM's "products" would include CDC's research, science, evidence-based advice, recommendations and tools. NCHM's "customers" would include health professionals, partners, individuals, institutions, industries, organizations and policymakers. Other components of NCHM's health marketing model include audience research, formative research, public engagement and partner engagement.

CDC's diverse health professional and public customers include >1,000 health departments, >1,000 partner organizations, >300 million Americans and populations in >50 countries. CDC is continuing its efforts to strike a balance between wholesale public health of conducting science and research and retail public health of directly engaging and marketing to the public.

The vision statement of NCHM is to create a world where all persons actively use accessible, accurate, relevant and timely health information and interventions to protect and promote their health and the health of their families and communities. NCHM acknowledges that a number of factors influence health, including genetics, social and physical environments, equity, behaviors and opportunities.

These factors and others play a key role when individuals make health decisions, such as family, friends, coworkers, physicians, clergy or other close contacts; deliberate, unintended or push-and-pull media; messages to promote and protect health; and policies, institutions or organizations. However, these factors are overloading consumers with health information on a

daily basis and are also increasing the difficulty for the public to make well-informed health decisions.

Moreover, health information is becoming more diluted due to the quantity and variation of messages. For example, the average informed individual reads or listens to at least seven sources of information each day from numerous channels that are available. In an effort to overcome these barriers, NCHM thoroughly reviewed lessons learned from the private sector in conducting health marketing activities. Most notably, newspapers, brochures, billboards, unidirectional web sites and other traditional or vertical media have dramatically lost their impact on the public and are largely being replaced by social or horizontal media, such as blogs, "You Tube," "FaceBook" and "MySpace."

Data from a number of sources show that consumers are now relying on "persons like me" to obtain information on health and other issues because the most trusted sources are no longer experts, companies or the government. NCHM is using CDC's credibility and expertise to aim for the "sweet spot" or nexus in its health communication and marketing activities. NCHM will take advantage of opportunities to use horizontal or peer-to-peer messaging to more effectively engage consumers, but will not entirely forego vertical media.

NCHM will apply a lesson learned from the private sector to ensure that CDC's products are always "within an arms reach of desire." A customer-centered approach to distribution will make the public more inclined to use CDC's products. NCHM also will develop effective public health strategies to provide health information and interventions when, where and how persons need these resources to make healthy decisions. In applying the private sector lesson, NCHM will ensure that "public health is within an arms reach of need." Dr. Bernhardt presented several images of products, services and tools that NCHM and the HCSOs developed to reach partners, professionals and the public through social media and other new media.

NCHM developed and implemented its 2008-2010 Strategic Plan with four programmatic priorities. Health behaviors will be promoted among the public through direct-to-consumer new media products, particularly CDC-TV. The accessibility, reach and relevance of electronic communication will be increased through mobile and other platforms under a new Content Management System. The accessibility of health information will be increased through health literacy research and leadership. Relationships will be leveraged through enhanced partner communication and engagement.

NCHM also developed its 2007-2012 Strategic Map with four strategic goals. The impact of health marketing sciences will be increased throughout CDC. Consistent and high-quality service and collaboration will be achieved. Strategic and innovative applications of health marketing will be expanded. NCHM's systems, operations and resources will be improved and sustained.

NCHM created the 2007-2012 Strategic Map with 20 strategic priorities and 30 strategic objectives for FY'07-FY'09 with quantitative targets, measures, metrics and organizational assignments. NCHM is currently developing a strategic performance and portfolio management

process to measure and track its progress in achieving the strategic plan priorities and objectives.

Dr. Bernhardt summarized the significant progress NCHM has made in its first three years of operation from 2005-2008. NCHM built its organizational capacity by clearly defining a mission, vision and values. A strategic plan was developed and priorities were identified. NCHM's structure was reorganized and officially approved. A workforce with talented experts and of incredible caliber was recruited, hired and developed. Internal communications were enhanced and numerous programmatic successes were achieved.

NCHM will conduct additional activities in 2008-2010 to improve its organizational capacity. The strategic performance management process will be launched to track projects, ensure accountability, achieve the 2007-2012 Strategic Map objectives, and implement programmatic priorities. Awareness of and support for NCHM will be increased throughout CDC. A partnership network will be developed and the focus on health equity will be enhanced. NCHM will build on its existing programmatic success. Dr. Bernhardt urged the BSC to provide input on NCHM's current and future activities, particularly its 2008-2010 Strategic Plan and other key focus areas.

Overview of the Division of Health Communication and Marketing (DHCM)

Dr. Cynthia Baur, Director of DHCM, explained that the purpose of DHCM is to enhance the research and practice of health communication, risk communication and health marketing at CDC and to provide evidence of effectiveness of public health interventions. DHCM's organizational structure includes the Community Guide to Preventive Services Branch; Marketing and Communication Strategy Branch (MCSB); and Emergency Communication Branch.

Dr. Baur summarized a number of DHCM's ongoing activities. DHCM is currently conducting an assessment to identify strategies in which the existing methodology of the *Community Guide* could be applied to a broader health marketing review. Findings from this assessment will be one of the most significant contributions to health marketing sciences from NCHM and DHCM.

DHCM is attempting to change the traditional practice of health communication and marketing because CDC has not historically developed products with a thorough understanding of or focus on its customers or distribution problems. To support this effort, DHCM is conducting activities with new types of health communication products beyond brochures, fact sheets and other traditional print materials.

At the branch level, MCSB is placing the concept of customer-centricity at the center of its marketing activities and practice. For example, MCSB established Team Leads to oversee "Healthy People" projects at every stage of life: school-aged persons 5-21 years of age, adults 22-65 years of age, older adults >65 years of age, and health professionals. The life stage projects and other functions will provide the initial basis for DHCM's structure, but more

specialists, interventions, products and other resources will be added as the volume of DHCM's customers increases.

Dr. Baur made several remarks for the BSC to consider in assisting DHCM's efforts to change the traditional practice and understanding of health communication and marketing. Caution should be taken in using "translation" because this word presents a problem for DHCM's health literacy improvement activities and might implicitly undercut or present complications in promoting the concept of customer-centricity. Although many elements must be added to basic scientific information to develop products that are usable to consumers, this process is not translation. "Translation" actually involves translating English products into other languages through cultural competence and communication.

Caution also should be taken in using "low literacy" because this term is pejorative, particularly in the context of health disparities, vulnerable populations and cultural communications. The BSC should provide DHCM with input on integrating social marketing insights and principles and persons with limited health literacy.

Overview of the Division of eHealth Marketing (DeHM)

Ms. Carol Crawford, Deputy Director of DeHM, explained that the mission of DeHM is to provide overall leadership to CDC's eHealth activities through a number of initiatives. Effective communication technologies will be created, designed, developed and evaluated to enhance the presentation and distribution of CDC's products and services. Assistance will be provided to CDC's information developers in planning, designing, testing and maintaining communication technologies. Leadership, management, guidance and direction will be provided for the CDC web site at CDC.gov.

A common look and feel will be developed for all CDC web sites and other electronic products and services. Leadership and management will be provided for the "CDC-INFO" telephone, e-mail and fulfillment services center. Research in user experience and communication technology areas will be conducted and supported. Tools, standards, guidelines, best practices and other resources will be created and distributed to assist CDC information developers in designing communication technologies.

Leadership, coordination or support will be provided for the identification, evaluation and implementation of CDC's new communication technologies. Knowledge of emerging and new communication technologies will be maintained and appropriate technologies for CDC to adopt will be identified. In-depth professional development in e-health and communication technologies research, design and evaluation will be provided to CDC staff through the "eCDC Seminar Training Series." Agency-wide leadership, coordination or support of CDC's presence will be provided in online social networks. Leadership, coordination or support of online collaborations will be leveraged with partners.

DeHM's organizational structure includes (1) DeHM OD; (2) the Digital Content and Marketing Branch with a Content Team, Marketing Team and CDC-INFO Team; (3) the Interactive Media Branch with an Interactive Technology Team and User Experience Team; and (4) the Broadcast Branch Division of Creative Services with DHCM's Emergency Web Team Risk Communication Branch.

The overarching goal of DeHM is to make CDC's content, tools, services and interventions available when, where and how users want these resources to improve their health, safety and preparedness. DeHM uses three major resources to achieve its overarching goal. One, the CDC web site at <http://www.cdc.gov> was redesigned in April 2007 and has received a number of awards since that time.

DeHM applies four principles to guide CDC.gov and CDC's other eHealth products and services. Decisions regarding the architecture, navigation, terminology, graphical interface and other features of CDC.gov will be based on research and data rather than opinions. CDC.gov will be based on the needs and wants of users, developed with continuous input by users, and tested with users. The success of CDC.gov will be measured based on quantitative and qualitative improvements in user performance and satisfaction. CDC.gov will be developed with and supported by CDC's web community.

Two, DeHM's new interactive media projects include mobile applications, social networks, blogs, gadgets and widgets, eGames, virtual worlds, podcasts, user-generated content, social bookmarking, eCards, image sharing sites and mashups. DeHM is placing more emphasis on social media because the use of social media is increasing among consumers and CDC must have a strong presence in this area to effectively distribute health information.

A number of social media attributes are relevant to health marketing. Interactive communication and a sense of community can be facilitated. Opportunities to disseminate information and strengthen the impact of CDC's science can be increased. Unique characteristics of emerging channels can be leveraged, such as user engagement, user-generated content, and user capacity to vote, map and bookmark sites.

Diverse audiences can be reached through tailored communications and marketing content. Users can be empowered to make healthier and safer decisions. DeHM developed and integrated an interactive media project with CDC's seasonal influenza campaign in 2007. The interactive media products included e-cards, graphical buttons, graphical badges for social networks, mobile alerts, bloginars and virtual worlds.

Three, CDC-INFO is a contact center that is available 24 hours per day/7 days per week/365 days per year for clinicians, other health professionals and the public to call or e-mail CDC. CDC-INFO also serves as a publication fulfillment center for persons to order CDC materials and a federal contact center during a pandemic influenza event or surge. Since February 2005, CDC-INFO has received 1.4 million telephone calls and 120,000 e-mail messages. CDC-INFO operators are available to answer questions in both English and Spanish.

A customer satisfaction survey was administered from October 2007-February 2008 and showed that 90% of 603 respondents found CDC-INFO to be a reliable source of information; 55.5% of 422 respondents wanted to change behavior based on information they learned from CDC-INFO; and 55.4% of 361 respondents reported making a behavior change. Ms. Crawford informed the BSC that a number of links to DeHM's interactive media projects were distributed in the meeting binders.

Overview of the Division of Partnerships and Strategic Alliances (DPSA)

Dr. George Roberts, Director of DPSA, explained that DPSA's organizational structure includes the Office of Communications, Private-Public Partner Sectors Branch, and Public Health Partners and Coordination Branch. The two branches conduct activities to build, sustain and expand partnerships in seven key sectors: businesses, faith-based and community-based organizations, education and academic institutions, healthcare, sports and entertainment, public health, and assessments and training. DPSA conducts these activities with <50 staff.

DPSA goals are to (1) establish, maintain and strengthen partnerships that advance CDC's health protection goals; (2) provide agency-wide assistance and leadership for partnerships; and (3) advance the state of knowledge of partnerships. DPSA has implemented a number of activities to achieve its goals, such as developing tools to assess its performance with partners; creating a *Resource Guide* to increase CDC's access to partnership research and skills; and designing a tool to measure relationships, track the progress of partnerships, identify the differential value of partners, and determine factors that impede or facilitate the effectiveness of partnerships.

DPSA has established three programmatic priorities. Partnership-related technical assistance, training materials and services will be developed for CDC entities that have an interest in expanding their partnership portfolios and strengthening partnership maintenance activities. Partner communication and engagement will be enhanced to increase CDC's reach and impact, particularly with state and local health departments and non-traditional partners that serve vulnerable populations.

Sector-based health marketing materials will be developed to engage traditional and non-traditional partners in collaborations that are related to CDC's health protection goals and priority interventions. DPSA's programmatic priorities are consistent with the vision of Dr. Julie Gerberding, Director of CDC. In April 2004, she stated that CDC's current and future partners are critical to achieving its public health protection goals and delivering its products.

DPSA created several partnership strategies to support its health protection plans. Coordinated strategies for partnerships will be developed with vulnerable populations. Products, services, markets and market opportunities for partnership services and support will be identified with special populations throughout CDC. A marketing program will be designed to promote culturally-based partnership services. New and non-traditional partnerships will be leveraged from organizations that represent vulnerable populations to advance CDC's mission and goals.

DPSA defines “vulnerable populations” as individuals or groups that have a disproportionate incidence or prevalence of disease, disability and death in the United States. DPSA uses “Pandemic Influenza Checklists” and a “Partners’ Portal” to reach vulnerable populations. DPSA’s other partnership resources are summarized below.

The CDC “Partnership Toolkit” provides technical information, resources, templates, and a variety of other strategies and tools to assist CDC, other professionals, and partners who represent vulnerable populations in maximizing partnerships. The toolkit includes tips to collaborate with specific sectors, a five-step process to develop partnerships, and research-based characteristics of successful partnerships.

DPSA collaborated with internal and external partners to develop the *Purchaser’s Guide* to translate clinical guidelines and medical evidence and provide large employers with information to select, define and implement preventive medical benefits. The CDC “Partner Web Site” has information on pandemic influenza preparedness, health promotion campaigns and other topics for partners. The “CDC Partnership Matters” electronic update is distributed biweekly to CDC’s partners around the world to provide information on CDC’s partnerships, public health initiatives and upcoming events of interest.

Overview of the Division of Creative Services (DCS)

Ms. Cheryl Lackey, Director of DCS, explained that DCS is charged with executing CDC’s communications strategy within NCHM. DCS strives to provide outstanding products and maintain excellent customer service. DCS was created in 2004 as a result of CDC’s “Futures Initiative” to support the agency-wide consolidation of business services, including graphics services, writer-editor services and the Global Health Odyssey Museum (GHOM). As of May 2008, DCS’s staff of 209 FTEs and contractors primarily included visual information specialists, technical writer-editors, health communication specialists, and audiovisual production specialists.

DCS was established to achieve four key objectives. The consistency, quality and availability of graphics, photography, writer/editor and other creative services will be improved across CDC. A career ladder will be provided for consolidated staff. Business services performance metrics will be applied to services that CDC offers through customer satisfaction, triage and tracking. Consolidated creative services will reduce costs.

DCS performs four major functions. Consolidated creative services are provided and managed throughout CDC, including graphics, writing-editing and photography. Collaborations are established to produce podcasting, video-on-demand and other new broadcast communication products. Oversight is provided for delivery of CDC’s press conferences, interviews and other inbound and outbound broadcast communications. The GHOM is used to educate visitors on the value of prevention-based public health and provide information on CDC’s rich heritage and vast accomplishments.

DCS provides internal service and support to CDC scientists, professionals and staff as well as to operating divisions in HHS. DCS's organizational structure includes the Broadcast Branch, Graphics Services Branch, Writer-Editor Services Branch, and Client Services Branch. The Broadcast Branch will launch CDC-TV in the summer of 2008 as a web-based education and information program.

DCS has made a number of significant accomplishments to date. Graphics and writer-editor consolidations were effectively implemented in 2005 and 2007, respectively. Broadcast services were seamlessly transferred from an outdated analog studio to a high-definition production facility in February 2006.

The GHOM averages >50,000 visitors each year. The widely popular "Disease Detective Camps" are sponsored to increase the interest of high school students in pursuing careers in public health. The web-based tracking and triage system receives ~8,000 service requests each year. Services are provided to >2,000 unique clients in CDC. Overall, 92% of customers rate DCS's services as "excellent" or "very good."

Ms. Lackey presented a series of products that the DCS branches developed for World AIDS Day in 2006, the 20th National Conference on Chronic Disease Prevention and Control in 2008, exhibits for the Global Tobacco Surveillance System, action plans for all 14 of CDC's goal action plans, materials for World Rabies Day in 2007, eCards for DeHM, the CDC Leadership Retreat in 2007, materials for the syphilis study at Tuskegee, CDC journals, and graphics for the National Center for Health Statistics and the "Second Life" project.

At the conclusion of the overviews, Dr. Bernhardt and the Division Directors provided additional details on NCHM's activities in response to specific questions posed by the BSC members.

- NCHM's annual budget of \$100 million breaks down to \$27 million for cooperative agreements to core partners; \$20 million for CDC-INFO; mandatory funding for other major programs; and salaries of FTEs and contractors. These mandatory items provide NCHM with limited discretionary dollars or funds that could be easily moved to invest in new initiatives. However, NCHM obtains funding from other sources, such as the CDC Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) and special appropriations from pandemic influenza dollars. Funding to the four NCHM divisions is not equally allocated because the divisions range in size from 40-50 FTEs to 209 FTEs.
- NCHM has a strong interest in conducting and prioritizing consumer research, but CDC and other federal agencies have clearance barriers to conducting certain types of research. As a result, CDC has traditionally implemented formative research on a small scale. A cultural shift would need to be made within CDC to emphasize the value of different types of data and package the information in ways that are meaningful and useful to customers. Overall, NCHM is at the beginning stage of exploring mechanisms to conduct consumer research and would welcome input from the BSC on this issue.

- NCHM views intramural and extramural research as one of its key gaps. In an effort to improve this area, NCHM intends to fund extramural peer review research in FY'09 that would be aligned with its programmatic and strategic priorities.
- NCHM uses its ten HCSOs to interact, communicate and collaborate with other CDC centers, but some of these processes are still being refined. An extensive overview on the role, function and activities of the HCSOs would be presented to the BSC on the following day.
- NCHM categorizes its internal and external activities into three groups: (1) consolidated services, such as graphics, writer-editors and the CDC-INFO hotline; (2) coordinated services, such as the CDC.gov web site; and (3) specialized services, such as the production of videos in the high-definition digital broadcast studio.
- NCHM has not clearly defined its customers at this time, but efforts are underway throughout CDC to focus more on direct-to-consumer marketing, communications and other outreach activities. NCHM has also launched the "Knowledge-to-Action" initiative to use marketing and other approaches to increase the wholesale distribution of CDC's information and interventions.
- NCHM received clearance from the Office of Management and Budget to perform a more rigorous evaluation of CDC.gov. NCHM awarded a significant evaluation contract to gather customer satisfaction surveys from web site users and collect a wealth of data from CDC-INFO users. NCHM is attempting to compile and analyze the enormous amount of data that has been collected to date from CDC.gov and CDC-INFO users.
- NCHM has responsibility for the CDC.gov home page and high-traffic areas, but the web site is completely decentralized. Each program is responsible for maintaining its individual web site on CDC.gov.
- NCHM has a great deal of interest in judgment decision-making research because this area is under-studied and under-applied in public health communication and social marketing. NCHM does not conduct judgment decision-making research at this time, but the BSC's input on strategies for NCHM to include this area in its health marketing portfolio would be welcome.
- Data show that CDC is one of the most respected government agencies. Moreover, CDC's brand adds value to its products for most audiences and NCHM leverages the CDC brand for greater health impact.
- NCHM did not narrowly define or prioritize its key audiences during its first two years of operation as a CDC National Center. NCHM placed more emphasis on consolidating services and establishing center-wide priorities, but NCHM is now in a better position to define its target audiences.

- NCHM uses various mechanisms to identify partners, such as the specific needs of a CDC program and existing relationships. NCHM categorizes its partners into various groups. The Association of State and Territorial Health Officials, National Association of County and City Health Officials, and similar groups are “funded” partners. Healthcare, education, faith and community organizations, public health, and sports and entertainment are “sector” partners. “Categorical” or “subject matter” partners are those in which NCHM serves as the primary point of contact, but other CDC centers collaborate with these groups as well. NCHM is organizing a “Health Marketing Leadership Roundtable” to convene a new sector of health marketing partners. NCHM will invite experts from organizations, companies and other sectors who have a strong belief in the power of health marketing to attend the roundtable. The BSC members are welcome to recommend names of additional participants.
- NCHM provides input and gives approval or clearance in some cases on the content of materials developed by other CDC centers. NCHM is increasing its level of oversight in the area of communication science, particularly for brochures and other materials that would be used to educate, inform and change the behavior of the public. NCHM has proposed a communication science clearance policy with criteria for cultural and linguistic appropriateness to ensure that target audiences are able to access culturally and social relevant materials. However, the BSC’s support and endorsement of this effort would be greatly appreciated because CDC’s messages, campaigns and other materials are not required to undergo NCHM’s proposed policy.
- NCHM will convene a workshop in the summer of 2008 for the Hollywood Health and Society Program to provide technical assistance and training to CDC staff on designing programs, products and messages with entertainment education.

The BSC was extremely pleased with NCHM’s understanding, vision and conceptualization of health marketing. The BSC greatly appreciated NCHM’s strong emphasis on eHealth, social media and new media models. Some of the members pointed out that no other federal agency has the same level of focus on health marketing as CDC. The BSC also commended NCHM on the outstanding CDC.gov web site.

Several of the BSC members made suggestions for NCHM to consider in refining its ongoing and future health marketing activities.

- NCHM should provide leadership in consumer research of health attitudes to serve as the “voice” for individual perceptions and behaviors regarding health in the United States.
- NCHM should invest more resources in research and place less emphasis on evaluations of its ongoing health marketing activities. Most notably, NCHM should gather empirical evidence to demonstrate the efficacy of various health marketing formats and activities. NCHM could use data from this research to increase the knowledge base on the role of e-media in influencing health behavior.
- NCHM should highlight its problems, concerns or issues in future presentations to ensure that the BSC gives helpful, realistic and feasible advice and recommendations.

With no further discussion or business brought before the BSC, Dr. Viswanath recessed the meeting at 5:25 on June 5, 2008.

Overview of the NCHM HCSOs

Dr. Viswanath reconvened the BSC meeting at 8:37 a.m. on June 6, 2008 and yielded the floor to the first presenter.

Dr. Katherine Lyon-Daniel, Deputy Director of NCHM, explained that NCHM has HCSOs embedded in most of CDC's National Centers. The HCSOs serve as a single connected unit and operate under one strategic plan for NCHM. However, HCSOs also have independent strategic plans for their respective National Centers. HCSOs convene regular meetings and are required to collaborate.

Associate Directors of Communication Sciences (ADCs) lead and manage HCSOs and serve as principal advisors to their National Center Directors on communication and marketing science, research and practice. ADCs are also charged with managing a complex set of relationships and competing priorities among statisticians, epidemiologists, laboratorians, behavioral scientists, public health analysts and educators in their National Centers.

ADCs have advanced degrees; years of experience in research, practice and the field; and expertise in the following areas: social marketing, qualitative and quantitative research, community engagement and mobilization, campaign development and assessment, emergency and risk communication, vulnerable populations research, branding, health and media literacy, and mass communication.

HCSOs directly report to the NCHM Office of the Director and indirectly report to Directors in their National Centers. HCSOs serve >90% of CDC, but no HCSOs are housed in COTPER, the Coordinating Office of Global Health, or the Offices of Minority Health and Women's Health in the CDC Office of the Director.

The core functions of HCSOs include communication science clearance for consistency and quality control; translation of science into products and messages; audience segmentation in various facets; situation and problem analysis; information dissemination and channel management; research and evaluation; and strategic planning. The secondary functions of HCSOs include risk and emergency communication, media relations, CDC brand management, project management, and training and technical assistance.

During the strategic mapping process, the HCSOs created shared strategic objectives and also developed specific objectives for their respective National Centers. Examples of the HCSO shared objectives include (1) identifying key partners and opportunities for collaborative projects; (2) creating a culture and environment that encourages innovation; and (3) increasing

references to and examples of health marketing in peer-reviewed communications and marketing literature by 5% by the end of FY'08.

Dr. Lyon-Daniel described several team projects that the HCSOs conducted in collaboration with CDC National Centers.

Project 1. The Seasonal Influenza Campaign is housed in the National Center for Immunization and Respiratory Diseases (NCIRD) with an overall strategy of partner relations. The purpose of these collaborations is to identify needs for information and materials; facilitate the distribution of recommendations and materials; keep key partners informed of developments; and extend the reach and frequency of CDC's primary messages.

NCIRD partnered with DPSA and DeHM in NCHM and other HCSOs throughout CDC to deliver influenza messages through new media channels and develop specialty influenza messaging to reach vulnerable populations, such as pregnant women and young children.

Project 2. The Fruits and Veggies-More Matters™ Campaign is housed in the National Center for Chronic Disease Prevention and Health Promotion with an overall strategy of branding. The "5 A Day for Better Health" Program was launched 15 years ago and was re-branded as part of an overall strategy to boost the intake of fruits and vegetables across the country.

The new brand was launched and tested in March 2007 with extensive endorsement by industry and organizations. Ongoing marketing and communications are underway to promote the brand to the key audience of "Generation X" mothers. Ongoing tracking and surveillance are also underway to monitor public knowledge, attitudes and practices related to fruit and vegetable consumption.

Project 3. The National Health and Nutrition Examination Survey (NHANES) is housed in the National Center for Health Statistics with an overall strategy of research and evaluation. NHANES data provide a snapshot of health and nutrition of the U.S. population among a broad range of age groups and racial/ethnic backgrounds. Solid communication and marketing are critical to NHANES because each participant represents ~50,000 other U.S. residents.

HCSO staff produced an adaptable informational video that is targeted to each community and established partnerships with local media, key local officials, the community and other stakeholders. NHANES data have been used to formulate lead abatement and obesity prevention policies for CDC and other federal agency and also to develop pediatric growth charts for physician offices.

Project 4. Travelers' Health is housed in the National Center for Preparedness, Detection and Control of Infectious Diseases with an overall strategy of audience research. The Travelers' Health web site has consistently ranked among CDC's top ten web sites.

The web site was revamped to establish and enhance a "one-stop-shop" web site for travelers' health information; assess the needs and interests of users and revise the web site accordingly; and continue to monitor web site usage and identify areas for modification. The redesigned

Travelers' Health web site was launched in August 2007 with country-specific information and a link to the *2008 International Travel Yellow Book*.

Project 5. World Rabies Day is housed in the National Center for Zoonotic, Vector Borne and Enteric Disease with an overall strategy of community mobilization and information dissemination. CDC led the communication effort for this global initiative in 62 countries around the world. Products from World Rabies Day included messages on the need to vaccinate pets and educational curricula for veterinary clinics.

Project 6. Descriptors for environmental public health categories are housed in the Agency for Toxic Substances and Disease Registry (ATSDR) with an overall strategy of translation of science. Toxicologists developed the hazardous category language 20-25 years ago, but the terminology has resulted in confusion, misunderstanding and fear among target audiences over this period of time.

ATSDR clarified the language to provide the public with a clearer explanation of its activities; determine how intended audiences perceive its messages; and apply solid risk communication principles to improve understanding in communities. ATSDR is evaluating the revised environmental health hazard categories at this time.

Project 7. Climate change message testing is housed in the National Center for Environmental Health with an overall strategy of information dissemination. The purpose of this project is to produce findings to assist public health communicators in effectively framing climate change messages for a range of audiences, particularly for communities of color, low-income populations, elderly persons and other groups whose health is expected to be most affected by climate change.

Project 8. The Teen Communication Project is housed in the National Center for Injury Prevention and Control with an overall strategy of cross-collaboration. A panel of marketing and communication subject matter experts from CDC, MySpace, Yahoo!, Black Entertainment Television and thinkMTV was convened to formulate overarching principles for teen outreach across a wide range of topics.

The expert panel held a meeting to provide input on communication principles, examine adolescent psychosocial and cognitive development theories, and focus on future message planning and implementation. Discussions are underway to maintain the expert panel as an ongoing resource for CDC.

Project 9. The Stigma Communication Research Project is housed in the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) with an overall strategy of reducing health disparities. HIV/AIDS communication messages that highlight racial/ethnic differences may increase stigma and other negative outcomes. As a result, the project is designed to frame messages and seek alternate approaches to reaching populations that are disproportionately affected by HIV/AIDS without creating stigma in these groups.

Project 10. Developmental screening communication messaging is housed in the National Center for Birth Defects and Development Disabilities with an overall strategy of overcoming barriers. This national motivational campaign was developed to caution parents, healthcare professionals and child care providers against ignoring the early warning signs of developmental delay.

The campaign was launched only three years ago, but data have already demonstrated the impact of this effort on increasing the knowledge of parents to recognize early signs of developmental delay and empowering parents to initiate a direct dialogue with healthcare professionals. The campaign also has provided healthcare professionals with resources to educate and discuss cognitive and social milestones with parents in a sensitive manner.

Moreover, NCHM is collaborating with two CDC centers to test messages to address public fears about the potential association between vaccines and autism and to educate parents about appropriate vaccination schedules for their children.

Project 11. HIV testing personal public service announcements (PSAs) are housed in NCHHSTP with an overall strategy of new media technology. This initiative was proposed to evaluate the impact of peer-generated messages delivered to mobile phones. Students will serve on teams to develop PSAs on HIV/AIDS and produce short videos that can be downloaded to mobile phones. NCHHSTP is closely collaborating with DeHM to create exciting, engaging and new media under this initiative.

Project 12. The Knowledge-to-Action (K2A) Initiative is housed in NCHM with an overall strategy of diffusion of best practices. A K2A Workgroup was formed to establish a common nomenclature to translate scientific evidence to actionable knowledge. NCHM anticipates that this initiative will provide a foundation for disseminating all of CDC's products and enhancing the state of communication science.

Dr. Lyon-Daniel requested the BSC's support and endorsement in three key areas. First, NCHM would welcome the BSC's support of the wisdom of a unified and consistent approach to conducting state-of-the-art health communication and marketing research across CDC. Second, NCHM would welcome the BSC's support of making organizational and structural changes to establish HCSOs and ADCSs in all parts of CDC.

Third, NCHM would welcome the BSC's support of maintaining the highest standards of communication and marketing excellence through consistent, evidence-based and audience-focused review and clearance of health communication and marketing products and messages for external audiences. The BSC would be most helpful in this regard by formally endorsing NCHM's proposed communication science clearance policy as a consistent approach to quality control.

Dr. Bernhardt provided additional details on the NCHM HCSOs. The HCSOs were initially created in response to Dr. Gerberding's decision and endorsement by the CDC Executive Leadership Board. However, separate and individual Communication Offices that were previously housed in CDC's National Centers had more capacity than the HCSOs. The current

decrease in capacity is a result of budget reductions and the establishment of new HCSOs for two more National Centers with no additional resources. The development of creative strategies to increase capacity of the HCSOs is a priority for NCHM.

Dr. Bernhardt pointed out that emergency response and risk communication are also important focus areas of the HCSOs. NCHM's linkages with the HCSOs facilitate its leadership role in the CDC Joint Information Center to create categorical expertise in emergency response and provide surge capacity.

Dr. Bernhardt clarified that the overarching goal of the HCSOs is to avoid duplication of efforts and take advantage of existing and new opportunities across CDC. Due to the diversity of the National Centers in terms of their customers, partners and other issues, NCHM is not attempting to mold the HCSOs into a "one size fit all" model.

NCHM is making efforts to build a flexible health marketing and communication system throughout CDC; identify and apply synergies where appropriate; increase scientific assurance and quality; and ensure that each HCSO meets the programmatic needs of its respective National Center. NCHM anticipates that its proposed communication science clearance policy, oversight and criteria will play a significant role in achieving these goals.

Dr. Lyon-Daniel, Dr. Bernhardt and the ADCSs provided additional details about the HCSOs in response to specific questions posed by the BSC members.

- The National Centers play a key role in defining their core audiences or primary customers for the HCSOs and ADCSs at the program or project level.
- NCHM is attempting to develop a standardized form or model to assist the National Centers in consistently identifying their audiences, objectives and other issues in the context of health marketing.
- NCHM has not received funding to date to develop or implement a specific campaign.
- NCHM formed the "Excellence in Marketing Committee" with representation by NCHM leadership, all ADCSs, and other CDC staff with marketing and communication expertise. The cross-cutting and collaborative committee convenes quarterly meetings and is chartered to establish health marketing priorities for CDC.
- NCHM is making several efforts to sustain its activities with the incoming Administration, such as developing a new health marketing partnership network; formalizing policies and procedures for activities that were previously ad hoc; compiling evidence-based successes of health marketing initiatives with a demonstrated track record of positive impact; convening the Annual National Conference on Health Communication, Marketing and Media in August 2008 in Atlanta, Georgia; enhancing the health marketing legislative agenda, priorities and key areas of growth in collaboration with the CDC Washington office; and conducting internal projects with the ADCSs to highlight the value of NCHM to CDC.

- NCHM supports the dissemination, practice, partners and other wholesale components of public health, but its active involvement in this area is not extensive at this time. The K2A Workgroup is charged with increasing the effectiveness of disseminating CDC's products to professionals, but this process will advance at a slow rate and require a major change throughout CDC. For example, CDC leadership and staff with various academic and practical backgrounds will need to endorse and reach consensus on wholesale public health terminology, such as "health marketing," "dissemination of best practices" and "translation." However, NCHM will take an agency-wide systems approach to have the greatest impact on improving wholesale public health.
- NCHM allocated ~\$500,000 in FY'08 to state and local public health partners to build local capacity in pandemic influenza preparedness. NCHM realizes that this level of funding is small, but technical assistance and evaluation expertise will continue to be provided to state and local partners and joint pilot studies will continue to be explored as well. To elevate the importance of state and local constituencies, NCHM will recruit a new Associate Director for Practice and Preparedness in the near future.

The BSC members made a number of suggestions for NCHM to consider in enhancing the HCSO activities.

- NCHM should create internal champions within CDC to showcase the value and benefit of health marketing and communication. NCHM should also use its state partners to advocate for health marketing and communication and make a strong case for the continued existence of NCHM. To support this effort, NCHM should provide technical assistance, data and expertise to state partners.
- NCHM should develop and disseminate case studies of its projects to leverage funding, attract partners, obtain endorsement of current health marketing goals, strengthen its existing infrastructure, and enhance the health marketing literature. NCHM should use the HCSO team projects as the foundation in developing health marketing case studies.
- NCHM should structure future presentations to highlight metrics, outcomes and results of its health communication activities.

Overview of Pandemic Influenza Risk Communication

Dr. Baur explained that the CDC Influenza Coordination Unit established Goal 4 as the risk communication goal to improve the timeliness and accuracy regarding the threat posed by an influenza outbreak with pandemic potential. To achieve this goal, CDC has assumed a number of scenarios for pandemic influenza planning.

All persons will be susceptible. Social and individual disruptions will occur on multiple levels. The timing and spread of a pandemic will be unclear. No vaccine will be available in the first six months of a pandemic. Multiple and different defensive strategies will be implemented in

different communities. High uncertainty and unintended outcomes will be likely on multiple levels of government actions. Communication challenges will be significant at all levels.

CDC and many other federal agencies are involved with pandemic influenza risk communication activities under the coordination of the Homeland Security Council and the White House. Of 150 tasks health risk communication tasks that have been assigned to CDC since 2006, 95 have been accomplished to date. However, other key issues have been delegated to CDC during exercises and briefings to the CDC Director.

CDC's overall measure of success in risk communication preparedness for pandemic influenza is the ability to be first, accurate, credible and consistent. The consequences of not meeting this goal will be a confused and misinformed public, different information sources, lack of agreement on core facts that form messages, lack of understanding of the need for audience-centric messages, and public perception of CDC as "just one more voice in the field."

CDC is using communication science and previous research findings to organize its pandemic influenza preparedness activities. The American Institutes for Research and the Harvard School of Public Health administered two national population surveys in 2005 and 2006 to determine the extent of public knowledge about pandemic influenza and communication issues. The surveys focused on knowledge, attitudes, beliefs (KABs), community mitigation strategies, media sources and trusted sources regarding pandemic influenza.

Another research project included five sets of focus groups in 2006 and 2007 to test messages for PSAs and the pandemic severity index. The focus groups measured KABs, community mitigation strategies and index messages regarding pandemic influenza. Message mapping and testing have been conducted to develop and test messages for pandemic trigger events. Communication, policy staff and subject matter experts from CDC and other agencies were involved in the development of five sets of message maps for various aspects of pandemic influenza.

Public engagement and stakeholder meetings were convened to consider the goals of potential pandemic vaccination and assign values to these goals. The public engagement meetings were used to refine vaccine prioritization guidance. After six meetings were held in three locations with culturally diverse adults, non-governmental organizations and community-based organizations, the use of public discussion followed by electronic voting and web-based dialogue was validated as a new public engagement strategy.

Key findings from pandemic influenza research projects with the general public are summarized as follows. Awareness about pandemic influenza and the perception of risk are low. Confidence is high in remaining at home with children. A strong desire exists for information. The government is responsible for addressing the problem, but individuals are responsible for taking actions. Preparations for pandemic influenza are minimal. A strong sense exists of persons who should have priority for vaccination.

CDC is conducting research with at-risk audiences to understand the daily lives and community supports of highly at-risk populations; assess KABs, capabilities and message needs related to

community mitigation strategies and the extent these audiences could adhere to them; and formulate and evaluate messaging.

Hard-to-reach audience segments for this research project include homeless persons; immigrants and refugees; poor, single-parent families and public housing residents; migrant workers, farm workers and other highly mobile low-wage workers; racial/ethnic and minority populations, including Hispanics, Asians, Native Americans and Indian Country Tribes; and persons with limited English proficiency and limited literacy groups. The methodology of the research project includes simulated video news stories, interviews with service providers, one-on-one and group discussions with audience segments, and development and testing of materials.

Preliminary findings from the research project with community-based organizations are summarized as follows. Risk perception differs and economics determine the level of response efficacy. Faith-based locations and radio channels are important. Differences in risk perception and response efficacy among ethnicities depend on acculturation levels, such as recent immigrants versus those who have lived in the United States for more than five years. Recent Asian immigrants have a low risk perception because of their experiences with war or other devastating events in their countries of origin.

CDC has developed five components for its risk communication strategic framework to be successful. Timely, accurate and consistent information will be provided. Rumors, misinformation and misperceptions will be rapidly dispelled. Credible spokespersons will be identified, trained and used to apply risk communication principles to all public messaging. All available channels of communication will be used and information will be proactively disseminated. Communication will be coordinated across all levels of government and with international and domestic partners.

CDC is taking a number of actions to support its risk communication strategic framework. A ready-to-go inventory will be developed with materials that provide various audiences with easy to understand information. The inventory will be audience-centered, actionable and easily disseminated with clear language. The inventory also will provide individuals with information when they need it and where they will receive or attend to it. The methodology to create the inventory includes discovery and gap analysis, communications planning, message and materials development, and materials testing. The theoretical underpinnings of the inventory include risk communication, social marketing, health literacy, and behavioral changes.

Dr. Baur presented a graph of messages and materials to illustrate the various stages of intervals between pandemic preparedness and response. These intervals include investigation, recognition, initiation, acceleration, peak, deceleration and resolution. CDC's mapping of a communication curve on top of the pandemic curve showed that communication objectives, messages and materials would have the most significant impact during the recognition, initiation and early acceleration phases.

Based on its previous and ongoing research as well as analyses of diffusion curves, CDC is conducting specific activities for each of the five components of the risk communication strategic

framework. Core messages, materials and risk communication capacity are being created to reach diverse public audiences. Situational awareness capacity is being developed for a larger media and communication environment. A media monitoring approach is being piloted through global media for avian and pandemic influenza. Information from the pilot is being used to inform briefings and exercises.

Investments have been made to train spokespersons in pandemic influenza crisis and emergency risk communications. A Pandemic Influenza Speakers Bureau has been established. New channels are being explored to disseminate information. Communication is being coordinated to strengthen and increase partnership communication capacity both domestically and globally. Presentations and webinars have been given to partner groups within the sectors of business, education, and community-based and faith-based organizations.

CDC has achieved a number of successes to date with its pandemic influenza risk communication activities. A framework was created for coordinating very diffuse communication activities across CDC. The consequences of a slow clearance process on communication success have been highlighted. Materials that are more audience-centered have been developed. Alternative message dissemination channels have been identified, such as on-hold messaging and pandemic influenza cartoon characters for children. A model for public engagement for vaccine prioritization has been validated.

CDC has also identified several challenges with its pandemic influenza risk communication activities. Government agencies have been criticized for adding to information overload; providing confusing information and recommendations; and not releasing information in a timely manner to assist persons in making decisions during an emergency. Dr. Baur asked the BSC to suggest actions that CDC should take to make pandemic influenza recommendations and information more usable to audiences and customers who need these resources.

CDC has high credibility with the public generally, but is only one "voice" in a crowded media environment. The media will use many sources in addition to CDC, but journalists will not wait for CDC to respond if they perceive that the response is too slow. CDC has developed a media strategy that includes engaging journalists and bloggers, participating in exercises and training spokespersons. Dr. Baur asked the BSC to suggest other reasonable actions that CDC should take to ensure an optimal government-media relationship during a pandemic influenza event.

Societal interest in preparing for a pandemic is low and will continue to decrease as time goes by without a pandemic. Dr. Baur asked the BSC to identify one issue that CDC must address to prepare the population for a pandemic.

The BSC members made several suggestions for CDC to consider in response to Dr. Baur's request for input on the pandemic influenza risk communication activities.

- CDC should address and better understand the rationale for "pandemic influenza planning fatigue," particularly among corporate businesses and consumers.
- CDC should identify a single credible voice in advance to represent the agency during the early phase of a pandemic influenza event. The spokesperson ideally should be a

media trained physician who has strong communication skills and knowledge of pandemic influenza.

- CDC should identify no more than four simple, clear and understandable messages that should be delivered to the public at the outset of a pandemic.
- CDC should develop innovative strategies for persons in various sectors of the federal government who will be involved in a pandemic influenza event to build personal relationships.
- CDC should closely collaborate with media anchors at this time to ensure that news broadcasts do not contain inaccurate messages or myths during a pandemic.
- CDC should take more aggressive actions at the community level because residents generally are not focusing on pandemic influenza. For example, CDC could advise families to prepare a "pandemic box" with necessary items.
- CDC should engage Health Hollywood and Society as a key partner in the development of pandemic influenza risk communication activities.
- CDC should use an influential entity in the healthcare sector to facilitate a dialogue on the need to train the media for a pandemic influenza event. This training should strongly emphasize that CDC is the credible source of information and content for pandemic influenza.

Drs. Baur and Bernhardt made a number of clarifying remarks in response to some of the BSC's suggestions. The Assistant Secretary for Public Affairs Office in HHS has been given responsibility for all pandemic influenza communications, but has delegated much of the preparedness activities to CDC. As a result, the Secretary of HHS and the White House will determine CDC's media role during a pandemic influenza event.

Public Comment Session

Dr. Viswanath opened the floor for public comments; no participants responded.

Open BSC Discussion

Dr. Viswanath led the BSC in an open discussion regarding the overviews that were presented and other aspects of the meeting. Key topics the BSC covered during the open discussion included the strengths and challenges of NCHM and process issues to refine future meetings. Comments and suggestions by the BSC members are outlined below.

- The overviews were helpful in terms of increasing the BSC's understanding of NCHM's structure, organization, mission, strategies, tactics, and its role within CDC.
- The breadth, scope, magnitude and range of NCHM's programs, activities and projects are impressive and amazing.
- NCHM has been thoughtful and deliberate in creating a structure, achieving goals, planning an evaluation of its activities, and placing a strong emphasis on results.

- Opportunities for the BSC members to meet, discuss issues and share ideas were extremely rewarding and will play a key role in the BSC's success and ability to collaborate as a team.
- The presentations were well organized and laid a foundation for the BSC's discussion. In the future, however, NCHM should use Dr. Baur's overview as a model in which specific questions were presented for the BSC to provide input. Briefing materials regarding the questions should be distributed to the BSC members in advance of meetings. For example, NCHM could circulate questions to the BSC on its extramural research agenda prior to the next meeting. This approach will help the BSC to be efficient and productive in formulating substantive recommendations to NCHM.
- The NCHM staff and CDC's recognition as one of the most credible and respected federal agencies in the country are two key strengths. The enthusiasm, credentials and commitment of NCHM staff are outstanding.
- NCHM should organize its requests for input from the BSC into specific categories, such as policy, partnership or internal issues.
- The ability of NCHM to establish operations as a National Center, develop a strong organizational culture and make a tremendous amount in progress in only three years is amazing.
- The BSC was concerned about the lack of resources due to the cross-cutting nature of NCHM's activities. Due to limited resources, NCHM should prioritize its activities.
- NCHM should be as flexible as possible and avoid overwhelming its products with process. Ongoing dissemination of solid products will encourage external champions to advocate for NCHM.
- NCHM should diversify its portfolio of state and local partners to create an advocacy base and strengthen its customer base. Partners are ready, willing and able at this time to provide support and advocacy to assist NCHM in becoming successful both internally and externally. A more comprehensive partnership portfolio will ensure that NCHM, as a fledging National Center, is more embedded within CDC and will be sustained over time.
- NCHM should play a key role in reaching and serving as a voice for underserved populations that are voiceless.
- NCHM should identify a staff member with strong skills in measurement and metrics to coordinate data collection efforts.
- NCHM should increase its focus on evaluation and be prepared to discontinue activities and products that have no demonstrated track record of effectiveness.
- NCHM should develop metrics for the BSC to evaluate its progress in six months to one year in resolving internal and external challenges, such as branding and partnerships.
- NCHM should give serious consideration to its brand and recognition for internal and external partners, such as general and information surveillance, equity in various health marketing activities, or leadership in the changing demographics of the United States in terms of language, culture and globalization.

Dr. Steven Solomon, Director of CCHIS, thanked the members for serving on the BSC. He emphasized that CDC views the BSC members as extremely powerful and important advisors, colleagues and partners. He clarified that the BSC was established to represent the public's

interest in ensuring NCHM produces, translates and applies the best possible science and uses its funding and staff in the most effective, efficient and productive manner.

Dr. Solomon explained that one of the BSC's most important functions would be to objectively evaluate NCHM's organizational structure and operations in terms of developing critical science and generating public health interactions. The BSC's advocacy, expertise in the field of health marketing, and validation of NCHM's activities would position NCHM to leverage more resources and continue to grow in the future.

Dr. Solomon noted that under Dr. Bernhardt's leadership, NCHM has made tremendous progress in attempting to change CDC's organizational culture and perception of "health marketing." Moreover, Dr. Gerberding has expressed unequivocal support of elevating health marketing throughout CDC. Dr. Solomon welcomed input from the BSC on approaches to make additional progress in this area and also requested the BSC's assistance in framing health marketing messages for external audiences.

Dr. Solomon concluded his remarks by emphasizing that he and Dr. Gerberding would be available to the BSC members at any time.

Mr. Walter Harris, Chief Management Officer of CCHIS, pointed out that the business community must make stronger efforts to inform the scientific community of the importance of business and management activities. Moreover, the business and science components of health marketing should not be separated. He asked the BSC to provide feedback on strategies for the business community to better support the science of health marketing.

BSC Business Session

Drs. Bernhardt and McDuffie noted that the BSC is chartered to convene two meetings per fiscal year, but additional meetings could be held by conference call if the need arises. Beginning in 2009, NCHM would attempt to convene the first BSC meeting in February and the second BSC meeting in August in conjunction with NCHM's annual conference. NCHM would distribute potential dates for the next meeting in 2008 to the BSC members.

Over the course of the meeting, the BSC members suggested several items to place on future agendas:

- Overview of NCHM's priority activities or "hot" topics.
- Update on CDC's pandemic influenza risk communication activities.
- Further discussion on process issues, such as an appropriate length of time for meetings to ensure that the BSC always operates with a quorum.
- BSC discussion on strategies for NCHM to strike a balance between intramural and extramural research.

Closing Session

The BSC thanked the NCHM staff members for their diligent efforts in organizing, planning and convening the meeting. The BSC was particularly impressed with the comprehensive meeting binders that contained PowerPoint slides from all of the presenters. The BSC also thanked the staff members for taking time from their busy schedules to give informative presentations and attend the meeting to answer questions.

Dr. Bernhardt thanked the BSC for providing helpful and valuable feedback to NCHM over the course of the meeting. The participants applauded Dr. Viswanath for chairing the first BSC meeting in an effective and productive manner.

With no further discussion or business brought before the BSC, Dr. Viswanath adjourned the meeting at 11:55 a.m. on June 6, 2008.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

Date

Kasisomayajula Viswanath, Ph.D.
Chair, Board of Scientific Counselors
National Center for Health Marketing

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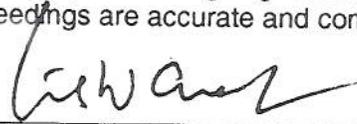
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8/8/08

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