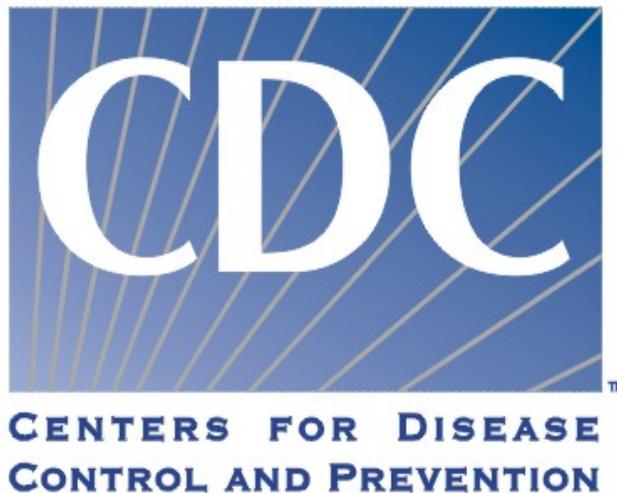


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
Coordinating Center for Health Information and Service
National Center for Health Marketing**



**Board of Scientific Counselors Meeting
July 14-15, 2009
Atlanta, Georgia**

FINAL Record of the Proceedings

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ATTACHMENT 1

List of Participants

BSC Members Present

Dr. Kasisomayajula Viswanath, Chair
Dr. David Ahern
Dr. Richard Bagozzi
Dr. Diana Cassady
Dr. Barbara DeBuono
Dr. Sonya Grier
Ms. Donna Nichols

BSC Members Absent

Dr. Marilyn Aguirre-Molina
Dr. William Smith

Designated Federal Official

Dr. Doğan Eroğlu,
Associate Director for Science, NCHM

CDC Representatives

Dr. Peter Briss, CDC Office of the Director
Dr. Steven Solomon, CCHIS Director
Dr. Jay Bernhardt, NCHM Director
Dr. Katherine Lyon Daniel,
NCHM Deputy Director
Robert Alexander
John Anderton
Diane Brodalski
Carolyn Brooks
Frank Ceo
Fred Fridinger

Donna Garland
Dawn Griffin
Shawn Griffiths
Scott Hale
Sabrina Harper
Jennifer Harris
Wendy Holmes
Valerie Johnson
Cheryl Lackey
Mary Lerchen
Stephen Luce
Max Lum
Dionne Mason
Jackie McClain
Kathleen McDuffie
Jeffrey McKenna
Jacqueline Melton
Jane Mitchko
Janice Nall
John O'Connor
Monica Ponder
Marilyn Radke
George Roberts
Craig Shannon
Kristine Sheedy
Linda Shelton
Lynn Sokler
Martha Vanderford

ATTACHMENT 2

Acronyms Used In These Meeting Minutes

BSC	—	Board of Scientific Counselors
CCHIS	—	Coordinating Center for Health Information and Service
CDC	—	Centers for Disease Control and Prevention
DMR	—	Division of Media Relations
DNPAO	—	Division of Nutrition, Physical Activity and Obesity
FTEs	—	Full-Time Employees
FY	—	Fiscal Year
H1N1	—	Novel Influenza A Virus
HHS	—	Department of Health and Human Services
HIT	—	Health Information Technology
JIC	—	Joint Information Center
<i>MMWR</i>	—	<i>Morbidity and Mortality Weekly Report</i>
NCHM	—	National Center for Health Marketing
NIOSH	—	National Institute for Occupational Safety and Health
NPHIC	—	National Public Health Information Coalition

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**BOARD OF SCIENTIFIC COUNSELORS MEETING
July 14-15, 2009
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 Board of Scientific Counselors (BSC) meeting. The proceedings were held on July 14-15, 2009 in Building 19 of the Tom Harkin Global Communications Center at the CDC Roybal Campus in Atlanta, Georgia.

Opening Session

Dr. Kasisomayajula Viswanath, Chair of the BSC, called the proceedings to order at 9:14 a.m. on July 14, 2009. He welcomed the attendees to the NCHM BSC meeting and opened the floor for introductions. The list of participants is appended to the minutes as [Attachment 1](#).

Dr. Viswanath noted that the new Administration reflects the most exciting and challenging time in the nation's history due to new reforms, ideas and opportunities. He pointed out the critical importance of both the BSC and CDC participating in and making contributions to these new developments.

Dr. Viswanath reminded the BSC that during its first two meetings, the members were impressed with the range of activities NCHM has been conducting and unanimously supported these efforts. The BSC submitted a letter to the new Secretary of HHS, Kathleen Sebelius, and the incoming CDC Director, Dr. Thomas R. Frieden, to formally express its views, support, sentiments and endorsement of NCHM's ongoing projects.

Update on Centers for Disease Control and Prevention Activities

Dr. Peter Briss, of the CDC Office of the Director, attended the meeting on behalf of Dr. Frieden. He agreed with Dr. Viswanath that the public health field has never been more exciting or offered as many new opportunities as the current time. He pointed out that one of Dr. Frieden's first tasks as the new CDC Director was to establish priorities for CDC: enhanced capacity in epidemiology and surveillance; stronger support to state and local health departments; increased emphasis on health risk behaviors, chronic diseases and other leading causes of death in the United States; an expansion of CDC's presence in the global health arena; and a solid role and voice for the broader public health community in health reform.

Dr. Briss was pleased to note that several of NCHM's current activities are aligned with Dr. Frieden's priorities. For example, health and risk communications will play a critical role in making a significant impact on risk behaviors and chronic disease prevention for the American public. The development and maintenance of strong partnerships will be an important effort in providing support to state and local health departments. The *Guide to Community Preventive Services* will continue to serve as an evidence-based resource to answer important questions on effective interventions, provide cost-effectiveness data, and describe concrete action steps in improving health and preventing disease in individual communities.

Drs. Briss and Jay Bernhardt, Director of NCHM, provided additional details on Dr. Frieden's priorities and new direction for CDC in response to specific questions and comments raised by the BSC members.

- Dr. Frieden reviewed the BSC's letter, but has not yet taken any specific actions in response to the recommendations. Dr. Frieden is currently gathering information from CDC management to make decisions on recommendations submitted by the BSC and CDC's other federal advisory committees.
- Dr. Frieden served as the New York City Health Commissioner for 7.5 years and is extremely cognizant of state and local issues, particularly the severe budget constraints and workforce shortages within states and localities. Dr. Frieden recognizes that the public health community will play a much more significant role in health care at this time compared to previous Administrations. For example, the HHS Secretary is focusing on the broader issue of "health reform" rather than "healthcare reform." Legislative bills that are currently being introduced to Congress have a stronger emphasis on public health areas outside of the healthcare system. The federal government will allocate a significant portion of American Recovery and Reinvestment Act dollars to provide support to state and local health departments.
- Dr. Frieden's public health priorities will drive the majority of CDC's internal activities and external expenditures of federal dollars. He has established high goals to ensure that CDC "wins battles" in public health. Most notably, Dr. Frieden and other high-level CDC staff have been spending a great deal of time on Capitol Hill to educate Congressional members on the importance of public health's role and voice in health reform.

- Dr. Frieden has been engaging in discussions with CDC management to rapidly and wisely spend prevention dollars to showcase and make prevention more visible than in the past and create a strong evidence base. However, Dr. Frieden recognizes the critical need to involve a broad range of stakeholders outside of CDC in discussions regarding the role of public health in making an impact on the most significant causes of health burden in the United States.
- CDC is actively engaged with the Office of the National Coordinator to make a strong case for taking advantage of inherent opportunities in utilizing approaches at clinical, individual and population levels. These strategies will include the use of interoperable data, sentinel reporting and electronic medical records as public health tools for surveillance and monitoring, identification of trends and measurement of progress on prevention issues. Dr. Frieden has emphasized the importance of combining public health and clinical medicine in the same continuum at both population and community levels. Gaps in knowledge and translation will be addressed in a number of priorities Dr. Frieden has established for CDC.
- Dr. Frieden places a great deal of importance on the critical need for a strong evidence base for CDC's health communication activities and efforts in other disciplines. However, Dr. Frieden will not allow CDC to avoid taking action on important public health issues in the absence of evidence.
- Health disparities will be paramount in Dr. Frieden's priority to address the leading preventable causes of illness and death because this goal cannot be achieved unless emphasis is placed on persons who are most affected.

Dr. Viswanath thanked Dr. Briss for attending the meeting to inform the BSC of Dr. Frieden's priorities and new direction for CDC. He confirmed that the BSC would welcome the opportunity to provide input and assistance in implementing the exciting new activities Dr. Frieden has planned for CDC.

The BSC was particularly pleased that CDC is capitalizing on health information technology (HIT) to promote a seamless continuum between discovery and delivery of public health issues. The BSC noted that telemedicine to reach rural areas and other HIT models could play an important role in creating innovative centers for clinical delivery and prevention. The BSC members made two key suggestions for Dr. Briss to convey to Dr. Frieden.

First, CDC should play a stronger role in developing, implementing, supporting, evaluating and investing in a field of study in which an evidence base is created for public health practice. Second, CDC should ensure that NCHM and the BSC are extensively engaged in Dr. Frieden's priority to address the leading preventable causes of illness and death because communications will play a central role in health disparities. For example, communications was a significant factor in informing the nation about the recent pandemic influenza across socioeconomic classes and geographic locations and other demographic differences.

In follow-up to the second suggestion, Dr. Briss confirmed that CDC would solicit input from the BSC to ensure its health marketing, risk communication and health communication of interventions do not make health disparities worse for underserved populations, such as persons with limited education or access to health information.

National Center for Health Marketing Director's Report

Dr. Bernhardt covered the following areas in his update. Dr. Frieden has established six key priorities for CDC: (1) strengthen the science base for CDC's activities, particularly in epidemiology and surveillance; (2) improve capacity to support state, local and city health departments; (3) engage in health reform discussions; (4) intensify CDC's activities in global health; (5) better address the leading preventable causes of illness and death; and (6) continue to strengthen preparedness and response capacity.

In preparation of the appointment of the permanent CDC Director, Dr. Richard Besser, the former acting CDC Director, established and charged a workgroup to identify CDC's internal organizational issues that the new leadership would need to address. To collect these data, the workgroup administered an agency-wide quantitative survey and held a series of focus groups with CDC employees. Key findings from these data collection efforts that relate to NCHM are summarized below.

Of all respondents, 42-50% had no knowledge or understanding of NCHM's function or activities. Respondents who answered this question were evenly divided between favorable and unfavorable responses. Feedback from the focus groups indicated that CDC employees lacked understanding and awareness of the role or activities of NCHM. Employees expressed slight dissatisfaction with NCHM's efforts to communicate with partners and the general public. However, NCHM was more concerned that employees were unaware of the nature or effectiveness of its communication efforts.

To address these issues, an organizational improvement process was initiated soon after Dr. Frieden assumed the position of the CDC Director in June 2009. Mr. Joseph Henderson is leading a team of CDC management and staff that is charged with collecting more input from both inside and outside of CDC, identifying areas of concern and other problems, and proposing solutions. The team will develop and report recommendations to Dr. Frieden to improve CDC's organizational functions.

The goal of this process will be to solidify CDC's role as a respected leader by the quality of its science, impact of its programs, and its public health outcomes in conducting business. CDC recognizes the need to serve as a public health agency that is attentive, connected, effective, efficient and a good steward of resources. Decisions that are made during the organizational improvement process will be promptly communicated and changes will be implemented as expeditiously as possible to increase effectiveness with the least possible disruption. CDC expects to implement as many changes as possible by October 1, 2009 and complete the entire organizational improvement process by December 2009. Dr. Bernhardt confirmed that the executive summary of CDC's organizational improvement report would be distributed to the BSC.

NCHM administered an anonymous online survey to all NCHM staff in June 2009 to measure its progress, improve its programs, and achieve the highest level of employee morale and satisfaction as possible. The survey respondents included full-time employees (FTEs),

contractors, fellows and interns and represented 61% of NCHM's 349 staff. Of all respondents, 70.4% had a good understanding of NCHM's mission; 67.3% strongly agreed or agreed that NCHM is a leader in the field; 70.5% were satisfied with their work at NCHM; and 62.8% were proud to work in NCHM.

In terms of job satisfaction at the current time compared to one year ago, 40.2% of respondents were more satisfied, 36.1% had the same level of satisfaction, and 23.8% were less satisfied. NCHM is currently analyzing 65 pages of qualitative data that were submitted in addition to the completed surveys, including positive and negative feedback as well as honest, critical and constructive opinions. Dr. Bernhardt confirmed that the final report of the NCHM staff survey would be shared with the BSC.

NCHM's fiscal year (FY) 2009 ceiling budget of \$105 million was severely cut with an 8.1% reduction in the salary and benefits line and an 8.2% reduction in the health marketing line. The Congressional appropriation did not provide specific language to explain the large budget cut or provide guidance to NCHM on managing operations with decreased funding. NCHM's budget cut affects all parts of CDC due to the collaborative and service-oriented nature of its activities.

NCHM's FY2009 budget cut has resulted in reductions of 3-26% in contracts and travel across all units; unfilled FTE vacancies and salary and benefit offsets in most units; elimination of planned grants and research programs; and severe funding decreases of 6-13% in NCHM's consolidated services, such as writer/editors, graphics, the CDC-INFO Contact Center and cooperative agreements. As Congress marks-up FY2010 appropriations bills over the next few weeks, partners and stakeholders will continue to make strong efforts to educate Congress on the implications of the FY2009 budget cut and the tremendous value of NCHM's activities.

The novel influenza A virus (H1N1) continues to be a major public health emergency and provided the first opportunity for NCHM to demonstrate its value in a comprehensive manner. A commentary was published in *Nature* to emphasize the need for communication to avoid the mistakes of the 1918 influenza pandemic. From April 21, 2009, 11 H1N1 reports were published in the *Morbidity and Mortality Weekly Report (MMWR)* as either standalone articles or "late breakers." During one 11-day period, four writer/editors, two desktop publishers and two web developers on the *MMWR* team worked more than 120 hours beyond their normal tours of duty.

HHS Secretary Sebelius visited CDC's Emergency Operations Center at the height of the H1N1 influenza response. CDC brought to bear nearly all of its tools, resources, activities, channels and capacities as part of the response. Most notably, CDC developed and disseminated a number of guidance documents, fact sheets and resources to the public; state, local and tribal health departments; public health departments; laboratories; and individual healthcare providers to ensure that information was accessible to various target populations. CDC created and distributed public guidance documents in multiple languages. More than 2.3 million CDC.gov pages related to the novel H1N1 influenza virus were viewed in Spanish and more than 100 CDC products, such as public service announcements, guidance documents and web content, were translated into Spanish and made available to the public.

The demand for information from CDC on H1N1 influenza dramatically increased in all formats, including the CDC.gov website and H1N1 influenza pages in both English and Spanish, e-mail updates, podcast downloads from YouTube, CDC-TV, social media and the CDC-INFO Contact Center. The views of CDC information reflected millions of persons and were unparalleled for public health and risk communications.

CDC actively engaged and performed outreach to more than 3,000 core funded public health partners and non-traditional partners across various sectors to disseminate information on H1N1 influenza to ~25 million persons. CDC also organized multiple telephone calls to the private sector and reached more than 2,500 small to mid-sized businesses. CDC is continuing to provide daily updates to its Partnership Portal website that reaches ~7,500 partners.

Dr. Bernhardt was pleased to report that CDC's response to the H1N1 influenza outbreak was consistent with the recommendations the BSC made to NCHM on pandemic influenza risk communication during the June 2008 meeting. The BSC advised NCHM to understand the rationale for "pandemic influenza fatigue," particularly among businesses and consumers; identify a single credible voice to represent CDC in a pandemic influenza event; identify a maximum of four clear messages to deliver during the outset of a pandemic; develop personal relationships with various federal sectors; collaborate with media anchors to ensure the accuracy of messages; take aggressive steps at the community level; engage Hollywood Health and Society as a partner; and engage the healthcare sector in dialogue on media training to present CDC as the foremost credible source.

CDC's response to the H1N1 influenza outbreak received extremely positive feedback from the media, particularly CDC's multiple communication formats to convey information on a serious matter, lessons the private sector could learn from CDC on effectively responding to an emergency, and CDC's use of social media to respond to an epidemic in the 21st century in a diverse and comprehensive manner. At the agency level, CDC's response to the epidemic was one of its proudest accomplishments in effectively reaching the public and professionals around the world. At the center level, NCHM employees made personal sacrifices to conduct amazing health marketing activities and deliver outstanding health information that made a significant impact on public health during the epidemic.

Dr. Bernhardt concluded his update by reporting on NCHM's progress in responding to recommendations the BSC made during the December 2008 meeting. Specifically:

- The BSC had advised NCHM to use the transition to a new Administration as a solid opportunity to mobilize and use its external advocates and primary end-users to widely publicize the value and strong contribution of health marketing to public health. In response, NCHM is continuing to collaborate with external partners and advocates to reinforce the concept of science- and evidence-based risk communications.
- The BSC had advised CDC to take advantage of existing opportunities to provide leadership in better defining the nexus between the public health system and healthcare delivery system. In response, NCHM will continue to utilize health communications, marketing, HIT and other breakthroughs to further combine public health and healthcare

in the same continuum to ensure that both sectors jointly address health issues at both population and individual levels.

- The BSC had advised NCHM to document its successes and impact as well as demonstrate its significant accomplishments, deliverables and outcomes that have been achieved in an extremely short period of time. The BSC noted that this approach would be particularly important to a new organization such as NCHM. In response, NCHM distributed the *Health Marketing Report* to the BSC, partners and stakeholders to raise awareness of its activities and showcase its successes.
- The BSC had advised NCHM to serve as a leader in formulating new alternatives to traditional public health. The BSC pointed out that NCHM has made more progress in eHealth than any other federal agency at this point. In response, NCHM is continuing to emphasize its ability to leverage new communication and marketing tools with an evidence-based approach that measures persons who are reached and the level of impact achieved through various channels.
- The BSC had advised NCHM to serve as a leader in health marketing research at the international level with the European Union or other countries that are conducting similar activities. The BSC further advised NCHM to serve as the leader in establishing a minimum set of criteria, standards or guidelines for health marketing research. In response, NCHM participated in a workshop with the European CDC to attempt to establish science-based criteria, standards and guidelines for health communication research and practice. NCHM will participate in another meeting with the European CDC, European Union, and U.S. government officials at federal and state levels in the fall of 2009 to create benchmarks that can serve as the basis for health marketing research.
- The BSC had advised NCHM to strengthen its knowledge of “public engagement” to develop effective strategies that motivate persons to take action in managing their individual health. Public engagement is a high priority for the current Administration in terms of providing a forum for the public and individual citizens to provide input on activities conducted by the federal government. CDC is a prominent leader in this area and will continue to emphasize the importance of engaging the public.
- The BSC had advised NCHM to widely publicize its evidence-based programming and health marketing activities that directly affect health equity. The BSC also recommended that NCHM take leadership in bridging gaps, inequalities and disparities in health outcomes and communications. The BSC further advised NCHM to use its existing resources to undertake this effort, including its strong credibility, expertise and commitment to health literacy. In response, health equity continues to be a high priority for NCHM. Most notably, Dr. George Roberts was recently appointed as the new Associate Director for Health Equity to expand this initiative and further close disparities in health information.

Dr. Bernhardt provided additional details on NCHM's activities in response to specific questions and comments raised by the BSC members.

- NCHM is aware that several BSC members and other constituents have expressed a strong desire to change NCHM's name to decrease the focus on "marketing" and place more emphasis on the science and evidence base of health and risk communications. Moreover, anecdotal evidence has shown that the term "marketing" has negative connotations among CDC colleagues, Congressional leaders, appropriators and other influential stakeholders. During CDC's ongoing organizational improvement process, consideration will be given to changing NCHM's name to more accurately describe the range of its activities and functions. NCHM leadership is open-minded to a potential change in its name and has submitted suggestions to CDC's Organization Improvement Team in this regard.
- NCHM closely collaborated with the Division of Media Relations (DMR), Influenza Division and many other parts of CDC in a team effort to oversee health and risk communications during the response to the H1N1 influenza outbreak. CDC's agency-wide team effort and Dr. Besser's extensive knowledge and background in risk communication principles were instrumental in informing the public and media of existing knowledge gaps and potential outcomes in the future related to the H1N1 influenza virus.
- CDC implemented a number of strategies to assist state and local health departments in responding to the H1N1 influenza outbreak. CDC provided daily telephone updates on the outbreak to members of professional associations representing state and local health departments and public health laboratories. Key messages on the outbreak were widely distributed to core partners in real time for further distribution to state and local health departments. However, CDC is currently identifying technological solutions for state and local health departments that have less funding and capacity to update electronic communications and information in real time. For example, CDC will make efforts to utilize automated tools to immediately provide state and local health departments with up-to-date information.
- NCHM will continue to gather data from public health, commercial and other sectors to compile evidence on health information disparities and identify the most effective strategies to reach various segments of the population. NCHM's Health Equity Council will play a key role in establishing specific goals, objectives and targets for health equity, health communication and risk communication and collecting information in these areas. Due to the difficulty in evaluating and measuring these issues, NCHM will charge the BSC's new Delivery and Discovery Workgroups with providing input on the relationship between health impact and health information that individuals use.
- During the response to the H1N1 influenza outbreak, CDC created four evaluation frameworks with logic models and the most recent science in evaluation to identify appropriate messages and materials, the most effective partnerships and technologies, and the most pressing needs in training and technical assistance. CDC has no funding to support the four evaluation frameworks, but has collected some metrics to date.
- CDC acknowledges the need to conduct more applied research on the integration between health outcome data and health and risk communications, intervention strategies, social and behavioral sciences, and the differential burden of disease to

make an impact on strategies individuals use to seek information and make health-related decisions. Under Dr. Frieden's leadership, CDC most likely will take a policy-oriented approach to these interventions to make changes at environmental and behavioral levels.

The BSC commended CDC on an outstanding response to the H1N1 influenza outbreak by demonstrating solid capacity and strong knowledge of a complex subject. The BSC also applauded NCHM on its remarkable public health efforts to provide real-time information and surveillance data to institutions, organizations and individuals throughout the world. Several members expressed their pride in serving on the BSC and being a part of CDC's important health marketing activities.

The BSC members made two key suggestions for NCHM to consider in strengthening its activities. First, NCHM should make a strong case to the Organizational Improvement Team to change its name. A new name would help NCHM in more widely promoting, publicizing and showcasing its assets, such as the *MMWR*, *Community Guide*, and other health and risk communication activities. The BSC advised NCHM to capitalize on Dr. Briss' previous experience with the *Community Guide* to support this effort and define its new direction under Dr. Frieden's leadership.

Second, NCHM should play a key role in the important field of health policy communications by increasing its expertise and knowledge of the evidence base in this area. Although health policy communications is an underdeveloped discipline in schools of public health and other organizations, the BSC noted that a number of groups are now using academic centers to provide training opportunities to integrate communications and health policy training. The BSC advised NCHM to thoroughly review the solid body of work on building and setting agendas that was developed over 30 years ago. This research would be extremely relevant to current efforts to advance the field of health policy communications.

Discussion on the Board of Scientific Counselors Discovery and Delivery Workgroups: Session 1

Dr. Doğan Eroğlu is the NCHM Associate Director for Science and the Designated Federal Official for the BSC. He noted that two documents were distributed to guide the discussion on the BSC's workgroups: (1) an excerpt from the December 2008 meeting minutes in which the BSC made suggestions and comments on the establishment of the new Discovery and Delivery Workgroups and (2) CDC's revised policy on peer review of research and scientific programs.

Dr. Eroğlu explained that the second document was circulated because all extramural and intramural research and scientific programs conducted or funded by CDC are subject to external peer review by a BSC at least once every five years to evaluate scientific and technical quality. The document describes all aspects of the peer review process, including its purpose and scope, background, policy and responsibilities. The document also contains references, acronyms, definitions, tools and additional resources.

Dr. Eroğlu advised the BSC to particularly focus on the “procedures” section of the revised peer review policy to gain an understanding of the external peer review process for research and non-research activities. NCHM would solicit input from the BSC on the most important issues that should be evaluated under the rigorous review process. The BSC and Dr. Bernhardt, as the Director of NCHM, would jointly identify and make decisions on programs or specific issues that should be peer reviewed. For example, the BSC could peer review a single study, research question, surveillance activity, or a larger division- or branch-wide project.

Dr. Eroğlu confirmed that NCHM would provide the BSC with descriptions of potential research and non-research activities to peer review. The BSC would then decide whether to conduct these peer reviews by division, branch or activity. To facilitate this effort, the NCHM Scientific Council is currently finalizing an inventory of all ongoing research activities and resources throughout NCHM and the Health Communication Science Offices in other centers. Dr. Eroğlu anticipated that the BSC most likely would establish subcommittees or workgroups to conduct peer reviews. These models have been found to decrease the burden of peer reviews on federal advisory committee members and allow outside experts to be engaged in the process as needed.

Dr. Bernhardt added that the revised peer review policy is CDC’s attempt to develop a standardized method for all BSCs to conduct peer reviews. He announced that NCHM intends to send the BSC its updated strategic plan, balanced scorecard data, CDC’s electronic communications plan and other strategic documents to review by the end of the calendar year. However, the BSC members would only be asked to submit comments or input on these documents based on their willingness or available time to contribute to these efforts. These strategic documents would not require formal peer review as described in CDC’s revised policy.

Drs. Bernhardt and Eroğlu were aware that a number of BSC members were unclear about CDC’s revised peer review policy in terms of specific outcomes, end-products and the overall process. Although many aspects of the peer review process are still under development, they provided additional details in response to the BSC’s questions. The end-product of all BSC peer reviews would be a set of recommendations to NCHM highlighting the strengths and weaknesses of the reviewed program. Dr. Bernhardt would then prepare a document in response to the recommendations to inform the BSC about specific actions NCHM would take.

Because NCHM has not yet provided the BSC with sufficient materials and guidance on conducting peer reviews under CDC’s revised policy, Dr. Eroğlu proposed that the BSC conduct the first review informally to become more familiar and comfortable with the process. For example, the BSC could use the Delivery and Discovery Workgroups to identify specific issues, important gaps or new areas that NCHM should prioritize. The BSC could then use the initial findings from the workgroups to conduct more formal and systematic peer reviews as outlined in CDC’s revised policy.

The BSC agreed to engage in additional discussion on CDC’s revised peer review policy on the following day. In the interim, the BSC asked NCHM to develop and distribute a specific format and consistent evaluation criteria to conduct peer reviews.

Dr. Viswanath turned the discussion to the BSC workgroups. He reminded the members that the BSC unanimously approved the formation of the Delivery and Discovery Workgroups during the December 2008 meeting. The purpose of the workgroups would be to provide the BSC with a forum to engage in more intensive and effective deliberations on NCHM's activities. The workgroups also would allow the BSC to more efficiently evaluate NCHM's role in addressing the public health needs of the country and filling gaps in discovery and delivery.

The BSC agreed that the Discovery Workgroup would be charged with assessing NCHM's leadership in answering substantive scientific questions, filling research gaps, and leveraging research opportunities through intramural and extramural research. The BSC agreed that the Delivery Workgroup would be charged with assessing NCHM's leadership in translating research and knowledge into actual practice.

Dr. Viswanath asked the BSC to provide input on three areas during the discussion: (1) the overall process, such as a six-month or one-year timeline for the workgroups to complete their activities; (2) logistics, organization and operations of the workgroups, such as the frequency of meetings, in-person or conference call meetings, and potential involvement of external experts and consultants; and (3) specific end-products, accomplishments, deliverables and outcomes of the workgroups.

Dr. DeBuono expressed reservations in convening the workgroups at this time in light of new information that was presented to the BSC during the current meeting, particularly CDC's revised peer review policy, strategic goals and new priorities established by Dr. Frieden. She was in favor of the BSC obtaining input and support for the Discovery and Delivery Workgroups from CDC leadership to ensure that the workgroups' activities would be consistent with CDC's new direction.

Dr. Viswanath noted that the concepts of discovery and delivery would continue to be important issues because public health would continue to be promoted through health communications and marketing. He pointed out that solid guidance from the workgroups would provide NCHM with an opportunity to play a leadership role in and set an agenda for discovery and delivery to improve public health. To address Dr. DeBuono's concern, Dr. Viswanath was open to expanding the charge for the workgroups to focus on health marketing and risk communication activities throughout CDC and in the field.

The BSC's comments in response to Dr. Viswanath's request for feedback on the workgroups are outlined below.

- The workgroups' recommendations should be timely, nimble and responsive to ensure that the guidance is relevant to NCHM and the broader public health community.
- NCHM should provide information and other resources to assist the workgroups in making effective recommendations. These materials should include budget data, policy reviews, and strategic planning documents from both NCHM and its partners.
- The workgroups should develop and disseminate interim products to NCHM, such as guidelines or approaches that could be presented in September 2009. This strategy

would allow the workgroups to be more time-sensitive and responsive to NCHM's needs while formulating the final recommendations.

- The first meeting of the workgroups should be structured with presentations by NCHM staff to allow the members to gather data to inform future meetings.
- The timeline for the workgroups to complete their activities should be set for one year rather than six months.

NCHM leadership made a number of follow-up remarks to the BSC's discussion. Dr. Bernhardt pointed out that the BSC is welcome to write a letter to Dr. Frieden to obtain his feedback on the Discovery and Delivery Workgroups. Based on Dr. Bernhardt's conversations with other CDC management, however, the workgroups are closely aligned with the priorities Dr. Frieden has established for CDC.

Dr. Katherine Lyon Daniel, Deputy Director of NCHM, added that health risk communications, marketing and media activities are conducted throughout CDC. As a result, a field perspective on these issues by the workgroups would be extremely valuable at both agency and center levels. She also announced that Dr. Frieden intends to make decisions on recommendations submitted by CDC's federal advisory committees in September 2009 at the end of the fiscal year and in December 2009 at the end of the calendar year. Dr. Lyon Daniel noted that the workgroups could use these two time points to evaluate their progress and direction in terms of new information, more important gaps and other developments.

Dr. Eroğlu emphasized the critical importance for the BSC to discuss and evaluate the needs and trends for the entire nation related to health marketing, communications and media. However, this analysis should eventually lead to recommendations that are specific to NCHM. He reminded the BSC that external consultants or experts could participate on the workgroups so long as two BSC members serve as the chair and a member.

Dr. Viswanath closed the discussion by describing the process for the first meeting of the workgroups. The BSC members would convene in their respective workgroups during the afternoon session of the meeting and the morning session on the following day. The membership of the Delivery Workgroup includes Dr. DeBuono as chair and Dr. Cassady, Ms. Nichols and Dr. Smith as members. The membership of the Discovery Workgroup includes Dr. Bagozzi as chair and Drs. Aguirre-Molina, Ahern and Grier as members. Drs. DeBuono and Bagozzi would report the findings of the two workgroups to the entire BSC on the following day.

Dr. DeBuono was uncomfortable with this process because two BSC members were absent and the charge, timeline, deliverables of the workgroups were still unclear. She was more in favor of the entire BSC reconvening during the afternoon session to discuss these issues in more detail. The members supported Dr. DeBuono's suggestion for the entire BSC to meet during the afternoon session to clarify uncertain issues. Several members acknowledged the need for more in-depth discussion to ensure that the workgroups would not duplicate efforts. The members also recognized the need to develop a process to bridge the workgroups' initial findings and final recommendations on delivery and discovery.

Discussion on the Board of Scientific Counselors Discovery and Delivery Workgroups: Session 2

Dr. Eroğlu asked the BSC to use the discussion to consider or provide input on the timeline for the workgroups to provide feedback to NCHM, outcomes of the workgroups' deliberations, and external consultants to engage in the workgroups.

The BSC members added that the discussion also should be used to clearly define “discovery” and “delivery;” articulate a framework and mission statement for both workgroups; and clarify the timeline, structure, deliverables and overall process of both workgroups. The BSC members noted that the structure or template of the workgroups should outline the reporting process, interim milestones, and data collection efforts based on materials provided by NCHM, input from external consultants, and existing models of similar reports from CDC's other BSCs.

The BSC's suggestions and comments on issues to refine the charge of the workgroups are outlined below.

Proposed Definitions

- “Delivery” should be defined as the dissemination of CDC's assets, innovations, research findings, solutions and products to end-users, such as health departments, individuals, institutions and the media.
- “Discovery” should be defined as a process of inquiry that employs a systematic approach or method to identify answers to specific and important research questions.
- Evaluation, partnerships and health equity should serve as guiding principles or value statements to bridge the feedback loop among discovery, development, dissemination and delivery.
- The “development” component should focus on NCHM's fundamental knowledge to legitimize and add value to the science of health marketing and communication in the field. NCHM should take leadership in integrating these components, identifying research, filling gaps and developing metrics for government agencies, foundations and non-governmental organizations.
- Consideration should be given to changing the name to the “Delivery/Information Workgroup.” This approach would allow the workgroup to focus on measuring the impact or effectiveness of actions taken when health information is delivered to the public.

Framework

- The underlying goals and objectives of discovery and delivery should be aligned with the prevention of illness, promotion of good health, and evidence or metrics to demonstrate effectiveness. The workgroups' evaluation of discovery and delivery also should be consistent with CDC's revised peer review policy to identify strengths, weaknesses, gaps, redundancies in research or program effectiveness to provide a basis for informed decisions regarding scientific direction, scope, prioritization and financial stewardship.

- The workgroups should consider the hypothesis that access to new media, knowledge, technologies and communications potentially could lead to better outcomes for social determinants of health.
- One of the workgroups should focus on the science base and validity of NCHM's activities to increase awareness or understanding of health communications and marketing and strengthen support of these efforts.
- Consideration should be given to identifying specific questions for the workgroups to answer (i.e., "What strategies can be used to deliver knowledge to end-users to facilitate the adoption and implementation of information?")
- The workgroups should obtain input from NCHM on the most important research projects, health problems or diseases to review at this time and then evaluate the delivery and discovery components of these activities. For example, the workgroups could assess risk communications of research projects that are closely aligned with priorities Dr. Frieden has established for CDC, such as preparedness for pandemic influenza or capacity to support state, local and city health departments in addressing tobacco, nutrition, physical activity and other leading preventable causes of morbidity and mortality. Alternatively, the workgroups could evaluate risk communications of research projects by categories, such as HIV and other infectious diseases or diabetes and other chronic diseases.
- The workgroups should use existing communication channels to pose questions to or obtain information from NCHM, such as telephone calls or e-mail messages to Dr. Eroğlu or Ms. Dionne Mason, the BSC Committee Management Specialist.

Resources

- NCHM should provide the workgroups with two key documents: (1) an inventory of the existing literature on delivery and discovery in the context of health and risk communications to various audiences and (2) a summary of CDC's ongoing activities and expenditures of human, organizational and financial resources in these areas
- NCHM should provide the workgroups with a summary of its current research portfolio, such as research by NCHM-funded Centers of Excellence and NCHM's intramural research projects. The summary should categorize the research projects by topics, populations, methods, metrics and results. The workgroups also should review the framework document that was developed by the CDC National Institute for Occupational Safety and Health (NIOSH). This document provided the Institute of Medicine with consistent and clearly defined guidelines to review, measure and grade the relevance and outcomes of NIOSH activities across multiple research portfolios. Dr. Max Lum of NIOSH confirmed that he would forward the framework document to Dr. Bernhardt for distribution to the workgroups.
- NCHM should assist the workgroups in gathering data from the upcoming "Weight of the Nation" meeting because the vast majority of the abstracts submitted were evidence-based. The meeting also will result in a national call to action to advance health policy and environmental change.
- NCHM recently compiled a list of various dissemination channels that CDC centers and divisions use to communicate with state and local programs. This list should be provided to the workgroups as an additional resource.

Products

- The workgroups should formulate recommendations on NCHM's current strategic emphasis, priorities, allocation of resources and existing gaps and also provide guidance on specific metrics to evaluate these areas. To facilitate this effort, the workgroups should conduct a situational analysis or needs assessment and use these findings to develop a policy brief outlining the background, top-level issues and recommendations.

Timeline

- Each workgroup should establish a goal of formulating two solid recommendations to present to NCHM leadership during the December 2009 meeting. NCHM and other parts of CDC would distribute documents to the BSC to obtain input on the organizational improvement process and other issues. Prior to the December 2009 meeting, the workgroups would complete smaller tasks and produce deliverables to NCHM that would not require evidence-based recommendations, such as a summary of the BSC's perspective on NCHM's current activities.
- The workgroups should formulate a set of key recommendations with specific examples for NCHM to most effectively deliver and disseminate knowledge that is discovered or developed. The workgroups should use staff in NCHM and other parts of CDC as a resource in collecting concrete data to support this effort. This approach would allow the workgroups to present progress reports to the entire BSC during the December 2009 meeting.

The BSC reached consensus on the following framework and process for the workgroups at the conclusion of its discussion. The Delivery Workgroup would focus on gaps, opportunities and areas of improvement in CDC's delivery and dissemination of information on pandemic influenza to state and local health departments; traditional, earned and social media; and vulnerable or hard-to-reach populations.

The Discovery Workgroup would focus on methods, metrics and measures to assess CDC's communications, tools, resources and quality of research on obesity. Health equity, vulnerable populations and metrics to demonstrate CDC's effectiveness in risk communications of pandemic influenza and obesity would be common themes for both workgroups. Based on the availability of resources, the Delivery Workgroup would aim to present its preliminary report and recommendations to NCHM in December 2009, but the Discovery Workgroup most likely would require additional time.

NCHM would assist the workgroups in engaging external consultants representing CDC's DMR, Division of Nutrition and Physical Activity and Obesity (DNPAO), Influenza Division, state and local health departments, the National Public Health Information Coalition (NPHIC), food industry, partner organizations, and BSC members of other CDC centers.

NCHM would establish a deadline for staff to provide the workgroups with the requested materials and other resources to ensure that the December 2009 deadline to present interim guidance was met. The workgroups also would review the literature to inform its discussions. For example, a study would soon be published describing successes in changing obesity rates

among a Hispanic population that utilized a community intervention with a primary focus on communication activities.

Drs. Bernhardt and Eroğlu made a number of remarks in follow-up to the BSC's discussion on the workgroups. In terms of the framework and process, the initial focus of the workgroups is timely because up to \$500 million has been proposed in health reform legislation to strengthen communication and marketing activities for obesity, physical activities and other prevention interventions. The workgroups' recommendations on discovery and delivery would be shared with NCHM leadership and other CDC centers as appropriate. Despite its current resource and budget constraints, NCHM is continuing to explore the possibility of developing a BSC website.

With respect to resources, NCHM would provide support in developing the BSC's policy brief and other products with assistance from staff in other CDC centers based on the availability of these persons. To facilitate this effort, the BSC should inform NCHM about specific staffing needs for the workgroups, such as a research assistant to gather and disseminate data or a senior researcher to actually write the policy brief. NCHM would facilitate conference calls with the workgroups as needed prior to the next BSC meeting in December 2009. NCHM also would identify and extend invitations to external consultants both within and outside of CDC to participate on the workgroups.

With no further discussion or business brought before the BSC, Dr. Viswanath recessed the meeting at 4:32 on July 14, 2009.

Overview of the Centers for Disease Control and Prevention H1N1 Pandemic Influenza Response

Dr. Viswanath reconvened the BSC meeting at 8:34 a.m. on July 15, 2009 and yielded the floor to the first presenter.

Dr. Bernhardt announced that two CDC leaders were in attendance to present a brief overview of CDC's H1N1 pandemic influenza response. Dr. Marsha Vanderford is Chief of the Emergency Risk Communications Branch, Director of the Emergency Communications System, and the lead for the Joint Information Center (JIC). Dr. Kristine Sheedy is the co-lead for the JIC and Associate Director of Communications Science in the CDC National Center for Immunization and Respiratory Diseases. Dr. Bernhardt presented a video to illustrate CDC's response in the early hours of the epidemic.

Dr. Vanderford reported that CDC is currently establishing a foundation in preparation of a potentially more severe H1N1 influenza outbreak in the fall. CDC is designing communication materials to ensure that information is disseminated in a timely fashion for individuals to take health protection steps. This information will provide the public with guidance on potential delays in school openings, respirators, and the use of antiretrovirals, influenza vaccination and other interventions.

The White House and HHS developed an overarching plan with three phases to prepare persons to act on CDC's recommendations. Phase 1 is planning activities to educate the public on the reemergence and increased severity of H1N1 influenza virus and raise awareness of informational resources that have been developed for communities and individuals. The White House and HHS are utilizing a variety of interactive media formats, such as public service announcements and a video contest, to widely publicize Phase 1 until mid-August 2009.

Phase 2 is an emphasis on the worst-case scenario with more severe influenza, an uptake in cases and a shortage of available vaccine for H1N1. These communications would focus on messaging for hand hygiene, social distancing, school closures and other individual protection measures. Phase 2 would continue until mid-October 2009. Phase 3 would focus on immunization as priority groups are identified and vaccine becomes more readily available.

CDC is conducting several activities to coordinate with the joint White House/HHS plan. DMR conducts weekly press events, including the publication of *MMWR* reports, to inform the public of the ongoing severity of the H1N1 influenza outbreak. CDC recently administered a poll that showed ~92% of the public is aware of the H1N1 influenza. Of these persons, 75% is continuing to closely follow the outbreak.

CDC is developing a social marketing campaign specifically targeted to the health and safety of travelers and activities along U.S. borders. This campaign includes the delivery of messages in airports and to the travel industry. CDC established a task force that is creating community measure guidelines for schools to remain open during an epidemic.

Dr. Sheedy announced that vaccination plays a significant role in the U.S. response to the novel H1N1 influenza outbreak. The HHS Secretary recently announced that a voluntary vaccination program would be available, but a number of issues and uncertainties have not been resolved to date. Most notably, CDC's Advisory Committee for Immunization Practices has not yet identified priority groups for which H1N1 vaccine would be recommended. Clinical trials that are underway have not yet provided answers on whether a safe and effective H1N1 vaccine would be available.

Public demand for H1N1 vaccine is unclear at this time. The request for CDC to implement the vaccination program presents unprecedented challenges in terms of programmatic resources and communications. The schedule for both seasonal and H1N1 influenza vaccination has not been determined. CDC's partners have expressed concern about the lack of concrete guidance and other materials. CDC is continuing to address public concerns and perceptions regarding the ineffectiveness of influenza vaccine or side effects. Influenza vaccine coverage is sub-optimal for critically important target populations, particularly healthcare workers, pregnant women and young adults with chronic health conditions.

CDC is taking a number of actions to address these issues. Focus groups are being held to assess the attitudes, beliefs and awareness of H1N1 and seasonal influenza and vaccination among various audiences, such as parents of children up to 10 years of age. Audience research conducted to date demonstrates the challenges associated with vaccine acceptance because many parents expressed reluctance or concern in giving their children a new vaccine.

Additional research over the next few weeks will include interviews with clinicians and surveys administered to the general public.

CDC is conducting scenario-based planning of the most likely vaccine recommendations. To support this effort, CDC recently released guidance to states to provide assistance in program implementation at the local level. This activity was undertaken because states were extremely challenged in adapting many of CDC's pandemic influenza materials and messages that were created in advance.

Drs. Sheedy and Vanderford provided additional details on CDC's H1N1 pandemic influenza efforts in response to the BSC's specific comments and suggestions.

- CDC's messaging of H1N1 influenza vaccine will be based on its traditional seasonal influenza communications, but important caveats will be conveyed to distinguish between the two vaccines.
- CDC plans to release revised guidance documents in August 2009 to inform the public of the appropriate time to return to work or school following a pandemic. CDC recognized the need to revise its recommendations with a broader range of options to facilitate local decision-making. This approach also would allow CDC to strike a better balance between public health protection and the safety of children, economic factors and other realities in the daily lives of individuals.
- CDC will convene a series of public engagement sessions throughout the country to obtain input from communities on its H1N1 influenza messaging and communications. CDC will evaluate and disseminate the findings from these sessions for implementation in the field.

Dr. Viswanath thanked Drs. Sheedy and Vanderford for attending the meeting to provide the BSC with a comprehensive overview of CDC's H1N1 pandemic influenza response. He confirmed that the BSC would welcome the opportunity to review and provide feedback on CDC's risk communication materials on the novel H1N1 influenza virus as time permits.

Coordinating Center for Health and Information Service Director's Report

Dr. Steven Solomon covered the following areas in his update. During a meeting with CDC management on the previous day, Dr. Frieden confirmed that CDC would undergo a number of organizational changes. Dr. Solomon commended Drs. Bernhardt and Lyon Daniel for their leadership in ensuring that NCHM staff continues to conduct outstanding activities in the midst of turmoil and anxiety associated with the upcoming organizational changes. He also recognized NCHM's extraordinary success in health marketing during CDC's response to the H1N1 influenza outbreak.

Dr. Solomon acknowledged that many public health professionals still do not fully accept or understand the fields of communication science, marketing science, information and knowledge management and the important roles of these disciplines in changing community norms outside

of disease categories. A more holistic view of public health is needed in the areas of marketing, informatics and health statistics to change community norms and social structures. Emphasis on a single disease or risk factor will not be a sufficient approach in achieving this goal.

As experts in the field of health marketing and communication, Dr. Solomon asked the BSC to make a strong and specific case for the types of capacities and functions CDC will need to successfully compete in the current marketplace and change social norms. CDC's capacity in health marketing and communication must be equal rather than subordinate to tobacco control, obesity prevention and other program specialty areas. The BSC's assistance to CDC will be critical in raising awareness about the existing body of knowledge in communication science and information management that cuts across disease categories.

Dr. Viswanath thanked Dr. Solomon for his remarks and confirmed that the BSC would welcome the opportunity to continue to support NCHM's activities in the interest of public health.

Workgroup Reports

Discovery Workgroup. Dr. Bagozzi reported that the workgroup agreed to conduct a situational analysis of obesity communications and marketing activities to identify the strengths, weaknesses, redundancies and measures of effectiveness in these areas. To inform the situational analysis, the workgroup would collect and review data produced by both CDC and non-CDC sources.

The members agreed that a liaison would need to be assigned to facilitate communications between CDC and the workgroup. The workgroup also expressed an interest in CDC staff joining and participating on the workgroup, particularly one or more research assistants and a staff member with solid knowledge of CDC's obesity communications and marketing activities. These persons would play a critical role in helping the workgroup to compile and review data. The workgroup would identify additional resources needed from CDC as its activities evolve over time.

The workgroup would consult with the Delivery Workgroup to obtain input in preparation of presenting its progress report during the next BSC meeting in December 2009. The workgroup expects the progress report to focus on promising interventions and next steps in obesity communications and marketing.

Dr. Grier reported that the workgroup developed an initial list of the types of research, information and resources needed to fulfill its charge. Over the next week, the workgroup would communicate by e-mail to refine the list before distributing the document to the entire BSC. The workgroup also plans to engage in e-mail communications to determine the types of skill sets that would be needed, identify internal and external consultants to engage, and focus on next steps.

Dr. Ahern clarified that the workgroup decided to present a progress report rather than interim guidance during the December 2009 BSC meeting due to uncertainties related to the breadth and scope of the data collection and review process as well as the ability of CDC to contribute resources in light of personnel and time constraints at this time. The workgroup agreed to first analyze CDC's obesity communications and marketing activities because gaps in these areas would inform decisions about experts and specific skill sets that would be needed both inside and outside of CDC.

The members agreed that the workgroup would develop a set of robust recommendations on obesity communications and marketing, but this deliverable would be produced after December 2009. The workgroup agreed to conduct three key activities prior to developing the final guidance document: (1) perform an internal review and situational analysis; (2) recruit external experts based on gaps identified in the internal review; and (3) analyze other obesity communication and marketing activities conducted by organizations outside of CDC. The workgroup agreed that a mid-term conference call with the Delivery Workgroup to discuss initial progress would be extremely helpful.

Delivery Workgroup. Dr. DeBuono reported that the workgroup defined its mission and framework as follows. The workgroup will recommend to CDC priorities for optimal delivery of CDC messaging, products and programs about pandemic planning to three audiences: state and local health departments, traditional and new media, and vulnerable populations. A secondary goal of the workgroup will be to identify gaps and research questions about existing delivery mechanisms and their impact. The members agreed that the workgroup would not address obesity communication and marketing until after the December 2009 BSC meeting.

The workgroup agreed that its membership should include CDC's resident experts in pandemic planning as well as the following external experts:

- A practitioner representing NPHIC (i.e., the Chief Information Officer for the state of Texas).
- A representative from the National Association of Community Health Centers (i.e., an individual, health center or entity with experience in communications for vulnerable populations at the clinical level).
- A state or local health officer with extensive experience in on-the-spot communications with the media on a regular basis (i.e., the state of Texas or California).
- Media experts (i.e., an Associated Press reporter or a former reporter at the University of Minnesota who currently focuses on emergency preparedness communications).
- A researcher with experience in conducting research on delivery of health-related messaging.

The workgroup identified its data needs from CDC in three categories: (1) names of pandemic planning experts housed in CDC; (2) CDC's definition of "vulnerable populations" relative to pandemic planning; and (3) a description of CDC's current pandemic planning activities to reach vulnerable populations, state and local health departments and media. The description of CDC's activities should include the content and delivery mechanisms that are currently being utilized for all three audiences as well as existing gaps in the delivery mechanisms. The

workgroup will conduct a literature review and analyze CDC's current allocation of resources to delivery of pandemic messaging.

The workgroup refined its process and timeline. During the December 2009 BSC meeting, the workgroup plans to distribute a draft findings and assessment document with a draft set of recommendations. To achieve this ambitious goal, the workgroup will collaborate with CDC to immediately identify and invite the internal and external consultants to participate on the workgroup's conference calls.

The workgroup will convene a two-hour conference call in September 2009 to review and discuss the information CDC provided. The workgroup will hold two 90-minute conference calls in October and November 2009 to brainstorm the draft recommendations. In between the conference calls, the workgroup will exchange documents, data from the literature, PowerPoint slides and other materials via e-mail. The workgroup also will collaborate with CDC to rapidly initiate the data collection process.

The workgroup discussed the need to identify staff with primary responsibility for extending invitations to the internal and external consultants. The workgroup agreed that an e-mail invitation from CDC would have a more powerful impact than a request from the workgroup. The invitation should be distributed as quickly as possible to ensure that the consultants are able to commit to participating in the first conference call in September 2009.

The workgroup noted that a research assistant would be needed to help with the literature review and collection of resource materials. The research assistant or another CDC staff member should be assigned to assist the workgroup in distributing the e-mail invitation, scheduling the three conference calls, and drafting the recommendations.

At the conclusion of the workgroup reports, the BSC and CDC engaged in a discussion to outline immediate next steps to advance the workgroups' activities.

- A note taker would participate on all of the workgroups' conference calls to capture the key points of these discussions.
- Consideration should be given to developing a template for both workgroups to follow. Existing templates should be reviewed as potential models, such as policy briefs, executive reports or workgroup reports from CDC's other BSCs. However, the template should be simple and focus on the three basic elements of a policy brief: the problem, outcomes based on data and recommendations.
- The Discovery Workgroup would attempt to produce a draft assessment outlining the current state of the science on obesity communications and marketing one year from now.
- The following materials would be provided to the workgroups: (1) references from a literature review of recent risk communication studies related to preparedness [to the Delivery Workgroup by Dr. Viswanath]; (2) references of Institute of Medicine reports that address risk communications of obesity and other chronic diseases [to the Discovery Workgroup by Dr. Viswanath]; (3) *Community Guide* articles on obesity communications [to the Discovery Workgroup by Dr. Lyon Daniel].

- The Discovery Workgroup should review CDC's evidence-based recommendations on obesity in the areas of nutrition, physical activity, screen-time and breastfeeding. Ms. Nichols offered to serve as the liaison between the Discovery Workgroup and the CDC DNPAO to facilitate this effort.
- Dr. Eroğlu would initiate the process of identifying CDC staff to assist and serve as experts and technical resources to the workgroups. He would serve as the initial point of contact between the workgroups and CDC.

Public Comment Session

Dr. Fred Fridinger, of CDC, noted that the BSC's process for forming the workgroups could serve as a model for new BSCs CDC establishes in the future in terms of providing scientific counsel.

Closing Session

Dr. Viswanath thanked the BSC members for agreeing to serve on the workgroups and complete other tasks as requested. He acknowledged the NCHM staff members for their diligent efforts in organizing, planning and convening the meeting as well as taking time from their busy schedules to provide valuable information. He also recognized Dr. Bernhardt for his outstanding leadership of NCHM, particularly in providing external partners and the general public with accurate, reliable and up-to-date information during the H1N1 influenza outbreak.

The participants joined Dr. Bernhardt in applauding Dr. Eroğlu and the other NCHM staff for planning and arranging the meeting. Dr. Bernhardt thanked the BSC for providing valuable input and making significant contributions to CDC and the broader public health community. He also acknowledged Dr. Viswanath's leadership in ensuring that the BSC meeting was efficient and effective.

With no further discussion or business brought before the BSC, Dr. Viswanath adjourned the meeting at 11:52 a.m. on July 15, 2009.

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