



COPR Alumni

CLASS OF 2012

- [Lora M. Church](#) (New Mexico)
- [Eileen Naughton](#) (Rhode Island)
- [Carlos Pavão](#) (Georgia)
- [John W. Walsh](#) (Florida)

Lora M. Church

Term: 2008-2012

Ms. Lora M. Church is a member of the Navajo Nation, Bitterwater Clan born for the Black Streak Wood Clan. She is the Senior Program Manager for the Acoma-Canoncito (To'Hajiilee)-Laguna Teen Centers. These school-based health centers are associated with the University of New Mexico Health Sciences Center and serve youth and families who reside on three American Indian reservations and in two Hispanic communities west of Albuquerque. Her key responsibility is helping define the interface between the primary prevention program and clinical/behavioral health, focusing on prevention and early intervention. She has more than 23 years' experience working in the health and human services field. In a previous position, she managed Native American Community Services, a nonprofit American Indian health and human services agency in Grefa cuo7 T 6. 89 0 Td]6.1(c)1.2xpfd,]6.1 Mfchfg8.1(2c 0 Twsu- 6k9 a)TJ0k204 Tc 0.0041 Tw -5.6995



Services Administration, Center for Substance Abuse Prevention (CSAP). In particular, he offers technical assistance and training to support cultural competency efforts, strategic planning, and evidence-based prevention programs and strategies at the regional, state, and local levels. Mr. Pavão also provides technical assistance to CSAP's Minority AIDS Initiative grantees.

Mr. Pavão has extensive experience with diverse communities, especially newcomer and underserved populations, and he has worked in both clinical and nonclinical settings. His subject and skill expertise includes more than 16 years in community development, evaluation, and public health programming. His interests include examining the cultural experiences of a population rather than race or ethnicity as a framework for developing health promotion tools.

Before joining EDC, he worked as community provider and project manager in HIV, substance abuse, violence prevention, tobacco control, youth development (especially sexual risk behavior), healthy school initiatives, and cardiovascular health and nutrition education.

Mr. Pavão has served as a board member for organizations that advocate for the needs of underrepresented segments of the population, including the Fulton County Commission on Disability Affairs, Georgia Equality, Atlanta Area Evaluation Association, and the Atlanta Lesbian Health Initiative. He presently serves on the institutional review board for Emory University and Morehouse School of Medicine. He has also been Commissioner of the Massachusetts Governor's Commission on Gay and Lesbian Youth.

Mr. Pavão received a master's degree in public administration from Bridgewater State College in 2004. He speaks English and Portuguese fluently, as well as conversational Spanish. Mr. Pavão resides in the historic section of Grant Park in Atlanta, with his partner James H. Doster and two dogs. In his spare time, he enjoys reading, theater, traveling, spending time with family an



DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
DIRECTOR'S COUNCIL OF PUBLIC REPRESENTATIVES (COPR)

JUNE 8, 2012

COPR MEMBERS PRESENT

DONNA APPELL, R.N.

~~GARDIS REGORAPHANZ.~~PTHT1R1NTf-0.0123 T0 -0.0009Tw 008(JU 0 LYNN2> OLSO

J U N E .

WELCOME AND DISCUSSION

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2 DR. TABAK: All right. So, I am assuming we are
3 live for the cameras since you have all already had a chance
4 to chat briefly.

5 I am Larry Tabak. I am the Principal Deputy
6 Director. I am here today because Dr. Collins is in London,
7 of all places, not London, Ontario, but London in the UK. He
8 does send his regrets, but he is looking forward to hearing a
9 summary of what has been discussed today.

10 I know you have already begun discussions about
11 the COPR origins and the various ways that people receive and
12 share and, importantly, act on information. Over time,
13 obviously, all of those modalities have evolved and have
14 changed.

15 So, the internet, for certain, has had a profound
16 impact on our society. I am told social media does, too,
17 although I confess that I am not up-to-date on any of that.

18 But, certainly, we are always looking, regardless
19 of what the technology is, we are always looking at better
20 ways to broaden public engagement. And so, it seems
21 opportune to sort of pause and say, how can we, going
22 forward, gather and consider input from the public in the

1 broadest possible way?

2 This morning I understand you heard from a number
3 of folks, Jon Carson from the White House Office of Public
4 Engagement, where I hear they bring in -- how many people a
5 day?

6 MR. BURKLOW: A hundred and fifty every day.

7 DR. TABAK: A hundred and fifty every day? Boy,
8 that would be quite a challenge.

9 And then, Justin Hermann from the GSA's Office of
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1 were quite a few places it was brought up that that question
2 itself is probably too broad. It is, how should NIH seek
3 broader public input on...?" And unless there is some
4 specificity to that "fill in the blank" -- so, you need to
5 know what the issue is and you need to know what the audience
6 is before you can really develop a meaningful strategy.

7 I would also say that I will raise the question,
8 and now this is related to what is the role of COPR going
9 forward. I think that, at least the way I remember it, it is
10 that COPR has been looked at with the communication possibly
11 both ways. So, it is getting input, advising on that, and,
12 also, advising on pushing information out, which I think is a
13 different question which might use different strategies. So,
14 I think that is part of the question on the table here: what
15 is the role?

16 DR. TABAK: So, information in versus information
17 out?

18 DR. OLSON: Right.

19 DR. TABAK: Obviously, they are not mutually-
20 exclusive, but they are different.

21 DR. OLSON: Ex12 ~~and~~ it gets back around to
22 that specificity issue. Because if we are not clear about

1 COPR.

2 MR. BURKLOW: It is just, how does NIH use social
3 media to engage the public?

4 MS. LAPHAM: Right. So, that is one question.
5 How does NIH use social media to engage the public? And
6 then, the other question is, what is COPR doing? So, there
7 is this fundamental issue of what COPR's role is. And they
8 are two very different questions, I guess is what I am
9 saying. Whether it is information in, like just giving
10 advice, versus spreading it back out, your membership might
11 be very different.

12 DR. TABAK: Let me ask you to elaborate a little
13 bit about pushing the message out. Because I appreciate
14 input in is in some sense member-specific.

15 MS. LAPHAM: Uh-hum.

16 DR. TABAK: You can have certain input. You can
17 provide certain input. If you have a sufficient number of
18 people, you eventually get a very broad range of input. That
19 is great.

20 But pushing information out, is that also member-
21 specific or is that a more generic possible function or role?
22 I mean, I am just asking. I don't know the answer.

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1 So, I know your background with dental. So, I
2 will give you a dental example. We know that periodontal
3 disease, if you have it, they said it is like the sixth risk
4 factor for diabetes. If you have periodontal disease
5 untreated and diabetes, you are likely to have difficulty
6 controlling your blood sugar. So, there shouldn't be a
7 health center out there that is not making sure that all
8 their diabetic patients are getting dental care, and yet
9 there is.

10 And so, I see pushing information is to say, you
11 know, we need to use these discoveries that we are investing
12 in as a nation, and we need to put it to work in our
13 clientele. That is one way I would see COPR collaborating.

14 We all have our own, you know, and let's put that
15 information to work and let's find ways of collaborating
16 better across these associations and to get that information
17 out in usable form.

18 DR. TABAK: Right. Let me push you a little
19 further, though. I think that is a very outstanding example.
20 Get a little bit more into the weeds for me. So, here is the
21 information. You review it. You know it is germane to the
22 Community Health Centers around the nation. So, then, what

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1 DR. TABAK: Right.

2 MR. NYCZ: So, then, I would be saying I would be
3 lobbying within that Association to get a push from the
4 Association that would make it receptive to a presence coming
5 from the agency.

6 MR. BURKLOW: And, Lynn, you had a comment?

7 DR. OLSON: Well, related to this, yes. I agree
8 with what Greg is saying. I think, though, that the
9 potential value of the kind of folks who have sat around this
10 table is that they are these conduits to the public. So, now
11 I am talking about the pushing information out, pushing
12 findings out.

13 So, you know, you have had really fantastic
14 patient advocate group2dpatient advocate g(ng)#eTd(had)Tj-0.0126Tc

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1 So, I think what I would have to say about
2 pediatrics probably applies to a lot of medical societies in
3 terms of mechanisms, how things work. So, it is a way of
4 learning from that and amplifying.

5 I will give what is one of our favorite examples
6 because it has been so u8390 TdMCI0136o sto say about

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1 MR. BURKLOW: I am curious; Donna has commented
2 before on this whole issue. Donna, can you comment on it,
3 please?

4 MS. APPELL: Well, just from what we were talking
5 about before, I think that there is so much social media, so
6 many ways that you can get a pulse of the people. I worry, I
7 want to be valuable, too. I want to look for how I am most
8 valuable.

9 And so, when I think about your biggest needs,
10 personally, having a lot of experience being at NIH, it is
11 that the NIH is terrible at playing their own trumpet. They
12 just aren't really great -- they are humble researchers --
13 and they aren't really great at getting the message out.

14 So, my real desire to help is trying to get the
15 message out. Even there is such a wealth of stuff going on
16 at the NIH, and I have a circle of trust and I have these
17 people that, if I send a message out, it is going to be a
18 pebble in a pond; it will go out further.

19 But I live in a world where people don't even
20 trust research, nevertheless, NIH. Like research isn't even
21 a friendly word in some cultures.

22 DR. TABAK: Yes.

1 MS. APPELL: So, we have a lot of work to do with
2 making the NIH palatable, not just in a scientific
3 breakthrough from some enzyme or something, but research in
4 general, and making it user-friendly and huggable and warm,
5 which I know the NIH is.

6 DR. TABAK: Right.

7 MS. APPELL: I know that side of the NIH. And I
8 really am struggling to figure out how we can best be most
9 usable to make it seem like the world's friendliest place.

10 You know, I am thinking stupid things, like it
11 would be great if there were a way for the social media to
12 actually be able to interface with these COPR members. Like
13 wouldn't that be cool if somebody could send an email to me,
14 as a COPR member? I am supposed to be representing the
15 public to the NIH. Does the public have anything, any
16 questions or something that they would like to ask or
17 something like that? And so, making us available to the
18 public; does the public know that the public is being
19 represented?

20 DR. TABAK: Interesting, yes. That is
21 interesting. Okay.

22 So, in other words, be sort of beacons. You

1 know, here we are, if you have any questions or --

2 MS. APPELL: I am supposed to be representing
3 you, and you know I am here, No. 1.

4 DR. TABAK: Right, right.

5 MS. APPELL: And do you have anything you would
6 want me to talk to them about? Or do you have any questions
7 about what the NIH is, about what I am representing? Start
8 there.

9 DR. TABAK: Yes. Well, that's interesting.

10 MS. LAPHAM: Just building on that, what you just
11 said, Donna, in the presentation from the man from GSA, he
12 talked about COPR could serve as, we could monitor sort of
13 some of the public feedback that comes in, just sort of sift
14 through and try to distill, a little different take, I think,
15 on what you are suggesting.

16 MR. BURKLOW: And that is just my idea of it, is
17 that the monitoring or pulse-taking or getting a sense of
18 what is going on that we may not otherwise know, but you
19 would be the filter of it.

20 MR. NYCZ: I guess the issue for me with the
21 monitoring is, again, we are just a few number of people with
22 only so much time. You guys have lots of folks. So, the

1 value of the monitoring, if there is a value to the
2 monitoring, it

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1 So, the reason I am raising all of this is the
2 right venue is when you are in the village perhaps or when
3 you are with a group, and so forth. And that is portable to
4 any set of issues, but this in particular, where you have
5 communities where service is so dominant in terms of concern
6 and thinking.

7 So, yes, maybe targeted outreach where you have
8 people's attention, because the venues that we often have at
9 our disposal, it may not be optimal.

10 MR. BURKLOW: So, just to encourage you to look
11 at the questions. It doesn't have to be in order, either.
12 So, if you see other questions you want to address --

13 DR. TABAK: Right. You know, it would be very
14 interesting for me if people would comment on face-to-face
15 versus other approaches. Because I am a self-confessed
16 luddite; I already said that. But you are all probably doing
17 this other stuff. So, I am just interested in what you think
18 about it.

19 MR. NYCZ: Well, I will just say I am with you.

20 (Laughter.)

21 And I liked your comment about the gold standard.
22 And we heard that, also, from the White House.

1 MR. BURKLOW: Actually, you heard it from
2 everyone, including Greg Albright whose business it is to be
3 in social media. He asked of everyone, "Who is on Facebook
4 and Twitter?" And a number of us raised our hands. And
5 then, he said, "Who is very active in the area?" And it is a
6 smaller percentage.

7 And his point was that everybody is talking as if
8 everybody is totally engaged in social media, and the reality
9 is you may be to certain degrees or not. So, not to look at
10 it as a panacea.

11 MR. NYCZ: And I would also say that kind of
12 keeping in the eyes and ears thing, we are your eyes and ears
13 in the community.

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1 agency, and that agency was going out in the communities and
2 handing out that free food to all the communities, everybody
3 would say, "Boy, I really love that agency." And the agency
4 never said who gave them the food. There is a problem with
5 that. And that is what I see.

6 And so, I come back here and I say I urge you
7 that your grantees should take up the flag and they should
8 help be out there. And that is a natural thing for them to
9 do, rally around. Let's circle the wagons, and we can all
10 grow, if that happens.

11 DR. TABAK: Well, I know it was a metaphor, but
12 we don't do food anymore, as you know.

13 (Laughter.)

14 It is a miracle that you even have --

15 MR. BURKLOW: We do water.

16 DR. TABAK: I brought my own, let the record
17 show.

18 (Laughter.)

19 Yes, certainly I take your point. This is one of
20 the things that drives me crazy and keeps John up at night,
21 I'm sure, is this lack of willingness to share in the glory,
22 if you will.

1 You know, the research was done at the University
2 of X, and our great investigators did it because we have this
3 wonderful research facility in the proud State of Y. And,
4 oh, the money -- "And we are wonderful," you know.

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1 see, their frequent face-to-face meetings, playing in the
2 overall goal of public engagement?

3 I don't want to talk the whole time. So, I would
4 encourage you all.

5 MS. APPELL: So, I will help with that.

6 MR. BURKLOW: All right. Thank you.

7 MS. APPELL: He was just mentioning that doing
8 social media is certainly where it is at and stuff, but he
9 actually felt that he got more out of it, then, once he has
10 engaged people in social media, to invite them back to the
11 White House for a face-to-face. And it was the face-to-face
12 meeting that actually congealed, that made it all more
13 palpable.

14 I think that discussion, if I remember correctly,
15 came up when we were also talking about how social media can
16 be difficult and problematic sometimes, certainly in
17 pediatrics where people worry about vaccines or those kinds
18 of things. He was saying that there is a great deal of
19 benefit to bring the people to the campus, let's say, to meet
20 the investigators, to meet the researchers. And that is when
21 they get into this circle of trust.

22 Did I do that well?

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MR. BURKLOW: Yes.

MS. APPELL: Thank you.

DR. TABAK: And I w

1 great value in increasing the granularity of the outreach. I
2 mean, in my former life, I did a fair number of these types
3 of talks, you know, community talks, Rotary-type talks, and
4 so forth.

5 It is always amazing; yo13

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1 that does great disservice to science, to take you back to
2 one that was a while ago, it was, well, women should get
3 mammograms after age 50. Now they should get mammograms
4 after age 40. No, no, no, it is 50. Now it's 40. And then,
5 the public doesn't see that.

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1 than I think NIH would.

2 MS. LAPHAM: They are structured differently.

3 MR. NYCZ: They are structured differently, yes,
4 but what I am saying is, to me, this is an opportunity.

5 DR. TABAK: See, in fairness -- I mean, I don't
6 disagree with what you just said; in fact, it is very
7 accurate -- but it is not our mission. See, CDC's mission is
8 to reach out and do the public health outreach. What we do
9 is we support the research that informs the public health
10 approach.

11 Now, as an aside, a little inside baseball talk,
12 I don't know if it is still true, but for year
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1 but certainly one of the preeminent spokespersons.

2 So, there are examples of that, but it is an
3 interesting point, when do we choose to step out and when do
4 we choose to stand behind our mission. So, it is an
5 interesting --

6 MR. NYCZ: Let me give you another one that
7 involves dental.

8 MR. BURKLOW: I can't believe it. Dental?

9 (Laughter.)

10 MR. NYCZ: The American Heart Association --

11 DR. TABAK: Yes.

12 MR. NYCZ: -- just came out as a result of a
13 recent publication in circulation.

14 You are familiar with that.

15 DR. TABAK: Oh, yes, of course. I funded the
16 work.

17 MR. NYCZ: So, NIH maybe should step out on this
18 one. Because the way they came at that made average people
19 and even clinicians think, oh, all that stuff about
20 connectivity, gone, because there is no causal relationship.
21 Yet, there were a couple of people who felt that they had to
22 write a disclaimer on some of this and say it, basically.

1 So, I am trying to convince our physicians that
2 dental and mental should be integrated for all these good
3 reasons. And then, I get blowback because, oh, the American
4 Heart Association said there is no connection. Well, you
5 didn't read it carefully enough. Let me help you.

6 DR. TABAK: The general principle that you are
7 raising is a good one. And when does NIH make the decision
8 to step out versus not?

9 MR. BURKLOW: Perhaps it wasn't a crisis or it is
10 a crisis in a way. The obesity in America and the HBO
11 series, you could argue that, well, we could tell the story
12 without NIH. Well, NIH funds the research that informs all
13 the public health practices and the clinical applications.
14 So, we actually have an extremely important role in it.

15 And so, we certainly will remain one of the main
16 players in it. So, it is a public health issue, but we were
17 bringing the science behind the health or the science that
18 will contribute to the health. And we do that in other ways,
19 Alzheimer's earlier last month.

20 MR. NYCZ: But I guess my point is -- and this is
21 getting us back to some of our past -- if you want to select
22 some people from around the communities, and you want them to

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1 as a group. And I wonder, like when we go around the table,
2 when you are here or when Dr. Collins is here, and we have to
3 give our little bit of three to five minutes -- you know, it
4 gets lengthy for some -- that is not leaving our hat at the
5 door, right?

6 But it gives much more color to the world we come
7 from. So, I kind of struggle with, is that really what we
8 need to be sharing? I think the more sort of focused we can
9 be around a specific topic, whether it is obesity or whether
10 the issue you discussed at the last meeting about race and
11 diversity among researchers, I think it is much easier to
12 leave your hat at the door when we have some kind of topic to
13 ground us on.

14 DR. TABAK: Right.

15 MS. LAPHAM: So, it doesn't really answer it, but
16 I think it is a very valid --

17 DR. TABAK: Well, no, no. No, it
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1 many organizations that I leave my hat at the door, so I
2 understand the whole idea not going to your own agenda
3 specifically. However, when you are with a group of people
4 that come from all different areas, my frame of reference and
5 my knowledge -- for instance, I work a lot with Puerto Rican
6 people and Hispanic people. I am not sure you need me to
7 leave my hat at the door in a way. You need me to bring my
8 perspectives, which is why I came to the table.

9 So, I understand that I don't want to talk
10 specifically about one particular disease process, but there
11 are some hats that I wear that you actually need to hear
12 from. So, I kind of try to temper that leaving that hat at
13 the door because you really need me, I hope someday. Maybe
14 someday I will prove to be needed in something like that.

15 So, I think along with not always leaving (ou a511 Tw
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1 challenge. How do you come up with the right mix of
2 individuals? And you do have a great mix here, but I don't
3 know if we should pat ourselves on the back. We may have
4 just been lucky that we picked the right people.

5 DR. OLSON: And I think this is a really relevant
6 question as you look to the future because there will be a
7 lot of slots to fill.

8 (Laughter.)

9 I think it does begin with, I think, some clarity
10 on this issue of what COPR should accomplish. But I guess my
11 observation is that what has been good about this group is
12 that it has had this diversity. And I know I came on, and it
13 was really, personally, being able to -- because I talk with
14 health people all the time, but from a narrow perspective,
15 right, a group of pediatricians mostly.

16 But what I think would be important to continue
17 to have around the table is this combination of you have
18 gotten great patient advocacy groups of different types. I
19 think it actually depends on the individual, well, with all
20 the members.

21 I think it is important to have the provider
22 community represented, and the different types. So, I think

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1 then he got down to 40, I think, or something like that, and,
2 ultimately, 20.

3 MS. LAPHAM: Right. So, there is the application
4 process piece, right?

5 MR. BURKLOW: Right.

6 MS. LAPHAM: There was a shared, it sounds like,
7 responsibility and sort of going through the vetting process.
8 So, that was one interesting piece.

9 But, then, the other piece about bringing
10 together experts from the field, like to say what should COtn8RTj-0.012

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1 DR. TABAK: I am actually going to have to excuse
2 myself.

3 MR. BURKLOW: Yes.

4 DR. TABAK: Thank you all for being here and for
5 all that you are doing.

6 MR. BURKLOW: We are going to follow up with Dr.
7 Collins as soon as we all can get together.

8 DR. TABAK: Great. Okay. Thank you all.

9 MR. BURKLOW: Thank you, Larry. Thank you.

10 MS. APPELL: Thank you for coming.

11 MR. BURKLOW: So, to stick with that question,
12 the measurable goals of COPR, in your mind, how do you see
13 telling somebody, "Oh, COPR is such a success because...." or
14 "We had this impact because...."?

15 Donna, you're up.

16 MS. APPELL: The COPR of the past, I saw their
17 goal. I saw their measurable outcomes. They published
18 things. They created things. There was stuff.

19 And I think that is because they had something
20 they had to do and they had to produce something. And so, I
21 have a hard time answering that question until we figure out
22 what it is that we are doing, for me to figure out what the

1 measurable goal for that project is. So, that's me; it is a
2 question I can't answer.

3 MR. NYCZ: As someone who has had his own
4 advisory committee and projects, I mean, part of my measure
5 on that would be for COPR, because Jon said so, I mean, or
6 Francis Collins said so.

7 The measurement of success of an advisory
8 committee is, did they have input that the people they were
9 advising found of value to help them? I mean, I think it is
10 as simple as that.

11 We are here to help you. If we are not helping
12 you, then let's not waste our time. If we are helping you,
13 then you just need to let us know. Our time is valuable. I
14 don't need anything more than that.

15 DR. OLSON: I would like to echo both of the
16 things that have been said.

17 MR. LEWIS: Yes, I would, too. And then, I know
18 when we first started, an article was published. Like I
19 think it was our second meeting, and it was exciting to see
20 how a discussion started on something important to NIH and
21 became a tangible product, which was then distributed in a
22 prominent journal as well.

1 And so, I think I would echo what Donna says. It
2 is kind of hard to have goals when you don't have a project
3 yet.

4 MR. BURKLOW: Okay. Just going back to the
5 questions here, I think we have identified all of them except
6 perhaps the next steps for COPR.

7 Go ahead, Greg.

8 MR. NYCZ: Well, I mean, kind of echoing what
9 Lynn was saying, a next step would be to kind of grow the
10 group a little bit, I think. Okay?

11 MR. BURKLOW: A couple of givens, for those of
12 you at home watching us today who wonder the size of the COPR
13 today.

14 (Laughter.)

15 Twenty-one is the capacity. We have hovered
16 around that for a while, but we have gone down and we haven't
17 re-upped, in part because of why we are talking today. I
18 felt that we needed a shift or at least an agreement causTj19wTj8 0 -0.

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1 want to do.

2 Oh, and that is a great point, too. There are
3 more members than this. It is just that we had to move the
4 date around a couple of times and probably threw several
5 people off. So, we have a larger group than this.

6 MR. NYCZ: But I actually like the way you
7 conceptualized this when we were talking before about like
8 rearview mirrors or blind spots, and so forth. But it is
9 another guard against that. If that is the kind of thing
10 that would be helpful, then that helps you in determining how
11 to select.

12 MR. BURKLOW: Yes, to grow the group. We
13 certainly will grow.

14 We can talk about the types of folks, and I think
15 we have already, the expertise, the background of people we
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1 may want to call on other outside experts as well.

2 The other point I think is to come up with at
3 least a sense of the group, issues such as inward versus
4 outward, you know, gathering input versus your role as
5 ambassadors, those types of things. Conveners, one option
6 would be you have decided to hold -- it is almost like you
7 are the planners for those meetings that the White House was
8 talking about this morning. Is that a role of COPR, to plan
9 a series of those types of meetings or one meeting, or
10 something like that? But you have helped design it, figure
11 out who comes, what they are talking about. So, it is not
12 just coming in and giving your individual advice, but you
13 have helped orchestrate or be the architects for another way
14 of getting advice.

15 MS. LAPHAM: I like that. And would it be
16 possible for the next meeting, between now and the fall
17 meeting, to have a small group come up with two or three
18 options of what COPR could look like and really think through
19 it?

20 MR. BURKLOW: Yes.

21 MS. LAPHAM: It is hard to do this.

22 MR. BURKLOW: Oh, yes. Yes.

1 before we recruit people to be on COPR and do all that.

2 So, one option might be that we end up being a
3 convening group, or at least a portion of the meeting might
4 be devoted to a particular topic you think that the NIH
5 should pay attention to. And we are not defensive about
6 things. So, maybe we have paid attention to something for 30
7 years, but you feel like it is time for us to pay attention
8 to it again or things have changed. So, we have to be open
9 to whatever you see.

10 And Larry said -- I didn't write down the phrase
11 -- but he did say sometimes we are so close to it, you know,
12 our perspective isn't as broad as yours. So, you are coming
13 in from the outside. You see things we don't see anymore.
14 It is like things in your house. You know, if you walk by
15 them every day, they become invisible. So, you need to say,
16 hey, look, you have that right there. That is one of the
17 things that I was talking about before, the blind spots. I
18 see an important function of COPR is to point out things that
19 are blind spots.

20 And a previous Director used to say we can't
21 start believing our own propaganda. I bring that up because
22 sometimes I think NIH needs to be not humbled, but needs to

1 be brought down to earth and say, yes, you are a great
2 agency, a great organization; however, you still need to pay
3 attention to some of these things. I think that is a role of
4 COPR, to be candid with us.

5 MS. APPELL: So, I think that is a great idea.
6 To have a focus group before the next meeting would be great,
7 and I agree with that and I would love to be a part of that.

8 I would also really like to have that PowerPoint
9 slide. I do a lot of public speaking.

10 MR. BURKLOW: We will make sure you get it.

11 And part of what we were talking about before
12 about the NIH communications plan, we are going to be putting
13 together a new version of that with some other messages as
14 well.

15 Yes?

16 MR. NYCZ: When we heard from the fellow from the
17 White House, the White House doesn't go through all that work
18 without wanting something in return. So, what we might want
19 in return might be a little different than what the White
20 House wants in return, but it would be helpful to try to
21 articulate what it is we would want. Because I could see, at
22 some level, if all you want to do is get the word out on what



1 Does that capture it accurately? Okay.

2 As part of the proposal, would this include the
3 types of members we are looking for? I don't see it being
4 tremendously different, but I think that has to be part of
5 the conversation as we look forward.

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1 practical standpoint, to have people who understand not only
2 what it is about, but the challenges facing it and things
3 that have been done or tried in the past, that kind of thing.

4 So, okay, any other?

5 (No response.)

6 I think we are kind of coming down to a time that
7 is sooner than 3:30, obviously. But we don't want to just
8 talk for talk's sake. So, does anyone else have any final
9 comments or questions?

10 Greg?

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1 months and vacations, so to make sure you are available.

2 But it is a good point. It has to be planned
3 when we are ready. That is the only thing. I know, yes,
4 that is true. It is true. It is true, right. Yes, and by
5 that time, you can invite the new members.

6 Greg?

7 MR. NYCZ: I was just going to say, it has to be
8 kind of, I mean, if you miss the fall meeting, you have got,
9 from what I can see here at least, three --

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1 the fall, we would sit down with the leadership.

2 MR. BURKLOW: Oh, no, no, no. I am seeing it all
3 in the summer. I would like to get it all done by August.

4 MS. LAPHAM: Okay.

5 MR. BURKLOW: Yes.

6 MS. LAPHAM: Okay.

7 MS. APPELL: Speaking as a member of the class of
8 '14 -- (laughter) -- I really think it is important, because
9 of this history and because of what we just listened to, and
10 because of the kind of growing pains that we are having, I
11 vote for keeping the class of '13 longer. I just want to put
12 that out there.

13 MR. BURKLOW: There is probably a good chance of
14 that.

15 MS. LAPHAM: What is the status of the current
16 application process?

17 MR. BURKLOW: We have applicants. I mean, we
18 have applications from a number of people from before. And,
19 yes, we can go through them and, also, if there are new --
20 well, you would certainly go through that pool, even if you
21 had new elements that you were looking for in the COPR
22 members.

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1 So, anyway, thanks again, everyone, and have safe
2 trips home.