NCIPC Board of Scientific Counselors
Open to the Public
February 16, 2021

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Atlanta, Georgia

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BOARD OF SCIENTIFIC COUNSELORS (BSC)
Centers for Disease Control and Prevention (CDC)
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Thirty-Fifth Meeting
Tuesday, February 16, 2021

Virtual Zoom Meeting
Open to the Public

Summary Proceedings

The Thirty-Fifth meeting of the National Center for Injury Prevention and Control (NCIPC, Injury Center) Board of Scientific Counselors (BSC) was convened on Tuesday, February 16, 2021 via Zoom. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA).

Call to Order / Roll Call / Introductions / Meeting Logistics

Victoria Frye, DrPh, MPH
Chairperson, NCIPC BSC
Associate Medical Professor
Department of Community Health and Social Medicine
City University of New York School of Medicine
City College of New York

Dr. Frye called to order the open session of the Thirty-Fifth meeting of the NCIPC BSC at 10:00 AM Eastern Time (ET) on Tuesday, February 16, 2021.

Mrs. Tonia Lindley conducted a roll call of NCIPC BSC members and *Ex Officios,* confirming that a quorum was present. The roll also was called following each break and lunch to ensure that quorum was maintained. Quorum was maintained throughout the day. A list of meeting attendees is appended to the end of this document as Attachment A. No conflicts of interest (COIs) were declared.

Dr. Arlene Greenspan reviewed housekeeping items, indicating that to make it easier to capture comments for the minutes, everyone should state his/her name prior to speaking. Minutes of the meeting will be part of the official record and posted on the CDC website at https://www.cdc.gov/injury/bsc/meetings.html. She reminded all BSC and *Ex Officio* members to remember to send an email to Tonia Lindley at NCIPCBSC@cdc.gov at the at the conclusion of the meeting stating that they participated. She indicated that members of the public listening in would remain in listen-only mode until the Public Comment period. Dr. Greenspan offered special gratitude to all of the BSC members who agreed to extend their terms to February 28, 2021 while awaiting new BSC members to come on board.

Dr. Frye welcomed the BSC members and *Ex Officio* members, thanking them for their time and continued commitment to injury and violence prevention. She acknowledged that everyone is very busy and expressed appreciation for the members taking time out of their schedules to participate on this important committee that provides advice to the leadership of CDC and NCIPC on its injury and violence prevention research and activities. In addition, she welcomed and expressed gratitude to members of the public for their interest and participation and indicated that there would be a public comment period from 03:45 pm to 04:00 PM. The meeting presentation slides were made available to participants at www.cdc.gov/injury/bsc. Dr. Frye said it felt like there had been an enormous amount of violence since the BSC last met and took a moment to recognize how devastating that has been, particularly the violence that occurred at the Capital on January 6, 2021. They are serving on the BSC because they want to prevent that sort of violence and all other violence, including interpersonal violence, violence associated with criminalization of drugs, and all of the ways these experiences can be made worse. She expressed gratitude to the leadership of CDC and NCIPC for leading the nation through such a difficult period in its history, and her peers and colleagues for having the courage to raise some of the issues that they have during their tenure on the BSC. She welcomed Dr. Judy Staffa, the new Food and Drug Administration (FDA) *Ex Officio* member.

Approval of Minutes

Dr. Frye referred members to the copies of the minutes from the July 22, 2020 and August 21, 2020 NCIPC BSC meetings included in their materials. With no revisions proposed, she called for an official vote.

Motion / Vote

Dr. Floyd made a motion to approve the July 22, 2020 NCIPC BSC meeting minutes. **Dr. Liller** seconded the motion. The motion carried unanimously with no abstentions.

Dr. Liller made a motion to approve the August 21, 2020 NCIPC BSC meeting minutes. **Dr. Floyd** seconded the motion. The motion carried unanimously with no abstentions.

NCIPC Director's Update

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Houry expressed her gratitude to the NCIPC BSC members for carving out time to join the meeting virtually, recognizing that many of the members are responding to the COVID-19 pandemic in addition to their normal duties and that everyone continues to face challenges in their professional and personal lives in taking steps to protect their loved ones and their communities from the pandemic. She then provided several NCIPC updates since the last BSC meeting.

The Fiscal Year (FY) 2021 Consolidated Appropriations Act was signed into law on December 27, 2020. It provided funding for CDC for the remainder of FY21, as well as some supplemental funding for COVID-19 relief and response. It provides over $682 million for NCIPC, which is a $5.5 million increase over the FY20 funding level for this center. The increases are to the child sexual abuse, rape prevention, suicide prevention, Adverse Childhood Experiences (ACEs), and the National Viral Death Reporting System (NVDRS) budget lines. The full report language includes 2 notable pieces that Dr. Houry highlighted. First, it has language pertaining to expanding NCIPC's overdose surveillance and prevention work that includes stimulants. The overdose epidemic is increasingly dynamic, so NCIPC appreciates the increased flexibility to track and respond to these changing trends. The second piece is the language on public safety officer suicide. Specifically, NCIPC was asked to use the increase in funding for the NVDRS to develop and maintain a public safety officer suicide reporting system. This is an important opportunity to better understand the burden of suicide among public safety officers.

In terms of how NCIPC plans to use the FY21 increases for the ACEs funding line, support will continue for state-level surveillance infrastructure that ensures the capacity to collect, analyze, and use ACEs data to inform ACEs prevention activities, support implementation of primary prevention strategies, and provide technical support to states. NCIPC recently funded the "Preventing Averse Childhood Experiences: Data to Action" cooperative agreement. This is a new program focused on building a state-level surveillance infrastructure that allows for the use of data to drive action in 4 states: Georgia, Connecticut, Massachusetts, and Michigan. NCIPC is excited about the opportunity to add more sites to that list. Over 35 applications were received for this work, so they would love to reach even more sites in the future. For the child sexual abuse subline, the $500,000 increase will be used to support new research that focuses specifically on prevention of adult and youth perpetration. This is a new subline for which 2 recipients are being funded to conduct research related to the primary prevention of adult-perpetrated child sexual abuse. NCIPC is excited about the opportunity to expand that research.

For the NVDRS line, the $1 million increase will be used to develop and maintain a new NVDRS module that will monitor and collect data on suicide among public safety officers. For the rape prevention and education (RPE) line, NCIPC will continue to support state and territorial health departments to initiate, expand, or enhance activities under the existing cooperative agreement. The funding will help to address needs, infrastructure enhancement, partnership development, and prevention strategies. For the suicide prevention line, NCIPC will continue to support the implementation and evaluation of a comprehensive public approach to suicide and recently funded a new comprehensive suicide prevention cooperative agreement that is focused on implementing a public health approach to suicide prevention with attention to vulnerable populations. Sites are currently being funded in California, Colorado, Connecticut, Massachusetts, Michigan, North Carolina, Tennessee, Pennsylvania, and Vermont. With this funding, it will be possible to go further down the approved but unfunded list. One of the highlights is that nearly 80 applications were received for this suicide prevention work, so there is certainly significant need to continue expansion of this work.

The Opioid Response Coordinating Unit (ORCU) has a critical role in coordinating a "One CDC Voice" on the opioid overdose epidemic, which means that multiple parts of the agency are working on the problem. The epidemic has evolved since the creation of the *2018 Strategic Framework for Prevention*. Given the new administration, the evolving overdose crisis, and the resurgence of stimulants-related harms, the ORCU framework will be updated over the next few months. NCIPC wants to ensure that the framework is forward-thinking and reflects the work occurring across the agency and identifies gaps. Several meetings will be convened with other centers across CDC that will be facilitated by an external consultant between March and May 2021, with a plan to develop the updates framework shortly thereafter. During a future BSC meeting, NCIPC looks forward to sharing the updates and efforts from across the agency for preventing overdoses. Given the evolving overdose epidemic and the added challenges of the COVID-19 pandemic, NCIPC has been actively enhancing its surveillance and prevention activities. NCIPC issued a Health Advisory Notice (HAN) in December 2020 to alert public health departments, healthcare professionals, first responders, and others about the increase in drug

overdose deaths primarily driven by synthetic opioids, such as illicitly manufactured fentanyl and increases in overdose deaths involving psychostimulants.

NCIPC published an article in the *Journal of the American Medical Association Psychiatry* (*JAMA Psychiatry*) titled, "Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic." This reported that of the 190 million emergency department (ED) visits, visit rates for mental health conditions, suicide attempts, all-driven opioid overdoses, intimate partner violence (IPV), and child abuse and neglect (CAN) were higher from mid-March 2020 through October 2020 during the pandemic compared to the same period in 2019.[1] Counts were highest for drug and opioid overdoses. In addition, NCIPC published a *Morbidity and Mortality Weekly Report* (*MMWR*) titled, "Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019" that showed a 4.3% increase in drug overdose deaths compared to the prior year. From 2013-2019, death rates involving synthetic opioids increased over 1000% and psychostimulant-involved death rates increased over 300%[2].

Given this, NCIPC has continued to heighten its prevention strategies and has developed a training video for public safety-led post-overdose outreach that will be disseminated through national organizations serving first responders; trained public health analysts on jail-based overdose education and naloxone distribution; will publish an editorial later in the month with a focus on saving lives now and reducing stigma; and is educating partners and grantees with a tool called FRED (A Framework for Reconstructing Epidemiological Dynamics) on the University of Pittsburgh website. This is an agent-based modeling system that originally was developed to simulate infectious diseases that now tracks opioid use disorder (OUD) and overdose outcomes.[3]

As the opioid epidemic evolves, it is critical to continue to address current issues while simultaneously mitigating future harms from the pandemic. With that in mind, NCIPC is very proud to be collaborating partners on COVID-related projects that intersect with injury and violence in ways that rise to the challenge of this time. NCIPC has received more than $35 million for COVID-19 work and more than 100 sub-recipients have received funding to address injury and violence during the pandemic. Dr. Houry noted that each of NCIPC's divisions would share more detailed updates on their COVID-19 related projects during the afternoon session.

As a reminder, the summer BSC meeting discussion was focused on race and health equity. Since that meeting, NCIPC has taken steps to a more equitable workplace starting with investing in the current workforce to ensure that there is significant growth potential and training, opportunities for promotion, and reaching the talented workforce outside of the center and the government. Progress has been made through activities such as having equitable opportunities for leadership positions through ensuring diverse hiring panels in terms of race, ethnicity, and inside/outside the center to have broader representation. NCIPC has funded 8 projects related to equity and racism and has included language in recently issued Notice of Funding Opportunities (NOFOs) addressing health equity and social determinants of health (SDOH). Dr. Houry now represents the Injury Center on CDC's agency-wide Diversity and Inclusion Executive Steering Committee, and NCIPC developed a Diversity, Equity, and Inclusion (DEI) Workgroup with a goal of identifying ways to strengthen the Injury Center's culture of diversity, equity, belonging, and inclusion. Part of this will include addressing the BSC's recommendations put forth during the last meeting. There was a lot of interest in this within the Injury Center. Through a competitive application process, 14 staff have been selected to work on this.

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[1] Holland KM, Jones C, Vivolo-Kantor AM, et al. Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* Published online February 03, 2021. doi:10.1001/jamapsychiatry.2020.4402

[2] Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. MMWR Morb Mortal Wkly Rep 2021;70:202–207. DOI: http://dx.doi.org/10.15585/mmwr.mm7006a4external icon

[3] https://fred.publichealth.pitt.edu/cdc_opioids

NCIPC is currently working with CDC's Hispanic Internship Program in collaboration with the Washington Center to have 10 paid interns for 15 weeks. Dr. Houry had the pleasure of meeting them all virtually earlier in the week. They are a very dedicated and enthusiastic group who she hopes find careers in public health and medicine, particularly in injury and violence prevention. This is a program that supplements academic study with practical experiences for students who are preparing to work in the public health field. NCIPC has supported its staff through resiliency sessions through the Employee Assistance Program (EAP) to foster discussion around acts of racism and violence. The Injury Center recently selected a consulting agency, Path Forward Consulting, to conduct a 3-month qualitative and quantitative assessment of the Injury Center's diversity, equity, and inclusion work. The ultimate goal is to understand where they are so that they can create an actionable plan for how to move forward together. They understand that this will not be an easy or simple task, but the Injury Center is wholly invested and committed to doing the work.

In terms of personnel updates, CDC recently welcomed Dr. Rochelle Walensky to serve as the new CDC Director. NCIPC is thrilled that she already has spoken about the importance of many Injury Center topics. Dr. Houry has several opportunities on her schedule this month to brief Dr. Walensky on NICPC's work, and they look forward to getting to know her better. They also congratulated Dr. Mildred Williams-Johnson for her retirement from CDC and are grateful for all of her efforts and coordination with the BSC. With Dr. Williams-Johnson's departure, NCIPC welcomes Dr. Derrick Gervin who is serving as the Acting Director for Extramural Research for 120 days. As NCIPC awaits approval of new BSC members, Dr. Houry thanked the BSC members who extended their terms by 6 months. She expressed her gratitude for all of the effort the BSC members have put in to guide NCIPC's work to advance injury and violence prevention. She expressed her hope that those who have been on the BSC for several years have seen how they have evolved to a point of engaging in bidirectional discussions and incorporating the BSC's recommendations into NCIPC's work. The past year is not what most of them anticipated. The pandemic has truly impacted everyone uniquely. Throughout the challenges, she has found some glimmers of hope. They have truly expedited some advances in their field that were a long time coming, such as increasing telehealth capabilities and finding innovative ways to ensure linkages to care despite the pandemic. While there is a long road to recovery for many of NCIPC's topic areas and communities that have been deeply impacted, Dr. Houry is confident that with resiliency, connectedness, and ambition, they will get through this together.

Discussion Points

Dr. Frye requested additional information about the new module for the NVDRS, which reminded her of the suicides of two of the Capital police officers following the insurrection and coup attempt. In addition, she requestion further information about what modules are available to track and survey violence perpetrated by police and public safety officers.

Dr. Houry indicated that for the suicide of public safety officers, this is a new module though they already collect suicide deaths. What is so rich and important about NVDRS is that it has the Coroner/Medical Examiner report, law enforcement report, and vital statistics. This provides an understanding of the situational circumstances that led up to the suicide death, such as relationship issues, job issues, medication use, et cetera. With the public safety officer module, some specific variables will be added to examine employment status (e.g., volunteer, part-time, full-time, retired), circumstances that led up to the suicide death, et cetera. To have a richer picture, they also are talking to their colleagues at the National Institute for Occupational Safety and Health (NIOSH) as well as other parts of the federal government to determine whether there are other data sources that can be pulled in. NVDRS does collect death by legal intervention or law enforcement. They reported on that a few years ago in the *American Journal of Preventive Medicine* (*AJPM*)[4], and this is published each year in the surveillance summary in the *MMWR*. This lists suicide deaths, homicide deaths, and deaths due to legal intervention. They have found that compared to other studies, they capture more of those types of deaths by combining all of them.

Dr. Compton said it was wonderful to see some of the publications and that he particularly liked the *JAMA Psychiatry* article, which was really nice work. He congratulated them on a terrific CDC Director. Dr. Walensky has been a longtime National Institutes of Health (NIH), and particularly a National Institute on Drug Abuse (NIDA)-funded scientist, so NIH has a personal stake in this and is very excited to see her taking the reins now. He observed that the overdose crisis is shifting from a focus on opioids to being much more of a polydrug use issue. He is struck that methamphetamine in particular is increasing. One of the issues is that it is not a passive situation in that drug sellers and drug marketers are actively distributing fentanyl and methamphetamine in new markets and new places. He asked Dr. Houry to share her thoughts about how those in the public health world could collaborate better with public safety. He has been particularly impressed with some of NCIPC's work with the High Intensity Drug Trafficking Areas (HIDTA) program and wondered whether she had any new ideas about how that might be expanded, possibly even together.

Dr. Houry said that NCIPC always welcomes collaboration with Dr. Compton and others. The public safety/public health focus is a great way to look at what is occurring on the ground, perhaps through sharing data through platforms like the National Forensic Laboratory Information System (NFLIS) or the Overdose Detection Mapping Application Program (ODMAP) system to look at the changing trends in near real-time. When they see numbers increasing, they are going through peer navigators, community health workers, and syringe services programs (SSP) to reach out to the people who are most impacted and at highest risk. One thing NCIPC is doing with public safety is considering ways to reach incarcerated populations or those who were recently released, given that they are known to be at very high risk of overdose. While they certainly need to stop acute overdoses, they also have to look at ways they can continue to engage in primary prevention through prevention of childhood trauma and other issues such as that, which lead to drug misuse. The HIDTA programs allow them to have a learning lab. They have a public health analyst paired with a drug information officer in 34 states now, but would love to expand into every state. They can share what they are seeing in the community, what homegrown innovations are working, and how these can be evaluated. This is a ripe opportunity to work together and to share lessons learned.

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[4] DeGue, S., Fowler, K. A., & Calkins, C. (2016). Deaths Due to Use of Lethal Force by Law Enforcement: Findings From the National Violent Death Reporting System, 17 U.S. States, 2009-2012. *American journal of preventive medicine, 51*(5 Suppl 3), S173–S187. https://doi.org/10.1016/j.amepre.2016.08.027

Dr. Cunningham pointed out that framing of this as the “opioid epidemic” has been somewhat shortsighted with all of the changes that have occurred with stimulants. Renaming and reframing this and thinking of it as the “overdose epidemic” is important because it is really not an opioid overdose epidemic at all. The focus on naloxone is so late in the process. That is saving someone at the very end of overdose. While prevention is of particular importance, treatment also is important. Only 20% of people who have substance use disorders (SUDs) receive treatment so treatment must be part of the solution, recognizing that various federal agencies have different roles. She also requested further information regarding the initiative to improve equity and whether there is external funding specifically for that.

Dr. Houry pointed out that NCIPC has focused a lot of its work on opioids because that is what their Congressional line includes. Now they have some flexibility with the inclusion of stimulants. The new framework now includes overdose response. They are very much evolving toward that, much of which is based on the Congressional direction they now have. They are considering how to expand this. In the past 2 years, they have taken into consideration how more polysubstance could be incorporated as part of opioids in order to address the emerging epidemic. They agree about linkages to care, warm handoffs, et cetera. She has engaged in some meetings with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of National Drug Control Policy (ONDCP) in the new Administration, and she is very excited that they are likely to have a lot of initiatives together in the future that will focus on this. In her mind, it is not just treatment but it is retention in treatment because polysubstance, methamphetamine, and stimulant users are much harder to retain in treatment. Health departments are important, but so are peer navigators in terms of helping with linkage to care. Related to equity, there are a few efforts. The BSC provided numerous recommendations related to research over the summer. The workgroup that Dr. Gervin is leading is reviewing those, prioritizing them, and will submit them to Dr. Houry and NCIPC in order to determine how to incorporate this into their work. Internally, the consultant will be engaging in a diversity assessment to look at qualitative and quantitative data. They just announced the consultant, so this work is just beginning, but they may have that consultant look at some of NCIPC’s external work as well. NCIPC is now a project to help build the pipeline of minority researchers. NOFOs now include more information to help secondary reviews allow for flexibility to bring in more diversity among researchers as well. NCIPC has tried to include the BSC’s recommendations from the summer into its ongoing work.

Suicide Prevention Strategic Plan and Priorities and Goals

CDC's Comprehensive Public Health Approach to Suicide Prevention

Deb Stone, ScD, MSW, MPH
Behavioral Scientist/Team Lead
Suicide Prevention Team
Division of Injury Prevention
National Center for Injury Prevention and Control

Dr. Stone presented on CDC's Comprehensive Public Health Approach to Suicide Prevention. NCIPC's suicide prevention work shifted to a new home in the Division of Injury Prevention (DIP) in October 2019 as part of the reorganization when NCIPC formed its new Suicide Prevention Team. The Suicide Prevention Team is now located in the Applied Sciences Branch of the DIP. Dr. Ann Dellinger is the Branch Chief and Mr. Alex Charleston is the Deputy Branch Chief. They are currently in the process of growing an interdisciplinary Suicide Prevention Team with several behavioral scientists, epidemiologists, and public health advisors. They are trained as a group in medicine, public health, psychology, education, and nursing.

In terms of the numbers, suicide prevention is one of 3 Injury Center priority areas. Between 1999 and 2019, suicide rates increased 33% and 2019 saw the first decline in suicide rates in more than a decade. Despite the small decline, suicide is still a significant public health challenge that took more than 47,500 lives in 2019, which equates to about 130 suicide deaths per day. As sad and tragic as suicide is, suicide deaths are just the "tip of the iceberg." Many more people think about, plan, or attempt suicide. According to the National Survey on Drug Use and Health (NSDUH), in 2019 about 12 million adults seriously thought about suicide in the past year, 3.5 million made a plan for suicide, and 1.4 attempted suicide[5]. This table shows the leading causes of death in the US by age group for 2019:[6]

Leading Causes of Death, U.S., by Age Group, 2019

Rank	10-14 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years
1	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Malignant Neoplasms	Malignant Neoplasms
2	Suicide	Suicide	Suicide	Malignant Neoplasms	Heart Disease	Heart Disease
3	Malignant Neoplasms	Homicide	Homicide	Heart Disease	Unintentional Injuries	Unintentional Injuries
4	Homicide	Malignant Neoplasms	Malignant Neoplasms	Suicide	Liver Disease	Chronic Lower Respiratory Ds
5	Congenital Malformations	Heart Disease	Heart Disease	Homicide	Suicide	Diabetes Mellitus
6	Heart Disease	Congenital Malformations	Liver Disease	Liver Disease	Diabetes Mellitus	Liver Disease
7	Chronic Lower Respiratory Ds	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus	Cerebro-Vascular Ds	Cerebro-Vascular
8	Influenza and Pneumonia	Influenza and Pneumonia	Cerebro-Vascular Ds	Cerebro-Vascular	Chronic Lower Respiratory Ds	Suicide

Suicide was the second leading cause of death among people between 10-34 years of age. While suicide decreases as a leading cause of death with age, the largest number of suicides in the middle years between 35-64.

In 2018, CDC released a *Vital*signs™ report which examined contributors to suicide in 27 states based on 2015 data, which found that 54% of suicides did not have a known mental health problem and many other factors contributed to suicide (e.g., problematic substance use, relationship problems, crisis in the past or upcoming 2 weeks, job/financial problems, physical health problems, loss of housing, criminal/legal problems). CDC now has more current data for

[5] https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases
[6] https://www.cdc.gov/injury/wisqars/LeadingCauses.html

34 states based on 2017 data for which the figures remain similar. These data suggest that in order to prevent suicide, all of these factors must be considered using a comprehensive approach described in the strategic plan and new funded program.

CDC's *Suicide Prevention Strategic Plan FY2020 - 2022* [7] was released in September 2020 and lays out the work for the team and the Injury Center for the next several years. The vision for suicide prevention is "No lives lost to suicide." The mission is to "Use data, science, and partnerships to identify and implement effective suicide prevention strategies to foster healthy and resilient communities across the US." The plan has four strategic priorities: Data, Science, Action, and Collaboration. One of the ways they assure progress across priorities is through research. Together, the strategic plan and the research priorities over the next several years will inform each other and hopefully amplify NCIPC's impact.

The first priority focuses on closing gaps in suicide data first by improving existing data sources and second by considering new and underutilized data sources, such as social media and syndromic surveillance. They will continue to explore novel data science methods for forecasting suicide rates in closer to real-time. Together, this two-pronged approach can help achieve a better understanding of the suicide problem. Based on the data, it is known that certain population groups experience higher rates of suicide than the general population (e.g., veterans, rural, and tribal communities). The second priority area, Science, aims to support research to improve the understanding of culturally relevant risk and protective factors in these populations. Based on what is learned about the population-specific risk and protective factors contributing to suicide, the goal moving forward is to evaluate prevention strategies impacting on these factors in vulnerable populations. Together, the data and science will inform preventive action—the next priority.

The Action priority includes Goals 5 and 6. Goal 5 focuses on the implementation and evaluation of a comprehensive public health approach to suicide prevention. Goal 6 is to translate the technical package of prevention strategies to make it more actionable, especially during times of infrastructure disruption. The final priority is Collaboration, which includes Goals 7 and 8. Collaborations with national, state/territorial, and local partners will help raise CDC's visibility and leadership in suicide prevention. The intent is to communicate program outcomes and lessons learned to the field and raise awareness with the public, decision-makers, and other stakeholders about why and how a comprehensive public health approach is critical to reversing increasing suicide trends.

CDC was thrilled to have received an appropriation for its Comprehensive Suicide Prevention Program in January 2020. In spite of COVID-19, NCIPC still received 85 applications. The enthusiasm for this NOFO speaks to the need in states and communities. CDC is committing a total of $7 million per year for 5 years to implement and evaluate a comprehensive public health approach to suicide prevention in order to reduce suicide morbidity and mortality, with attention to one or more vulnerable populations defined as those populations with greater rates of suicide than the general population in the jurisdiction. From among the 85 applications received, 9 sites were awarded funding. The program has two main activities, which include creating a strategic action plan that lays out the comprehensive approach and implementation and evaluation of that plan. This action plan has the following 5 key components or activities:

- ❑ Creation of a multi-sectoral partnership plan
- ❑ Use of surveillance data to select vulnerable population(s) and to understand circumstances of suicide in the population(s)
- ❑ Creation of an inventory of ongoing suicide prevention programs in the jurisdiction(s) and identification of prevention gaps and opportunities for enhancement
- ❑ Selection of strategies & approaches from the CDC Suicide Prevention Technical Package to complement existing strategies

[7] https://www.cdc.gov/violenceprevention/pdf/suicide/SuicidePrevention_StrategicPlan-508.pdf

- ❑ Development, implementation, and evaluation of a robust communication and dissemination plan for stakeholders comprised of successes and lessons learned

One of the major components of the comprehensive approach is selection of strategies and approaches from the *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*.[8] Former CDC Director, Dr. Frieden, described a technical package as a select group of strategies based on the best available evidence to help communities and states sharpen their focus on priorities with the greatest potential to prevent a public health problem, in this case suicide. This graphic provides a snapshot of the technical package, with 7 strategies indicated in the bold purple text with multiple approaches or ways to advance these strategies shown below each:

The technical packages address the many risk and protective factors associated with suicide at the individual, relationship, community, and societal levels. Funded recipients use this resource to select multiple strategies to implement and evaluate in the identified population.

[8] https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

The second main activity of the funding mentioned earlier is implementation and evaluation of the comprehensive approach, including evaluation of individual strategies and the overall approach. An evaluation of individual strategies is intended to identify promising as well as ineffective strategies. Evaluation of the overall plan will assess intermediate and long-term outcomes, as well as the interaction of strategies, contextual factors, policies, and partnerships. Evaluation through tracking of indicators and metrics will be ongoing with continuous quality improvements made as needed.

NCIPC is funding 8 states and 1 university. The applicants included state and local health departments, universities, tribes, territories, and non-profits, including human service organizations, veteran serving organizations, and representation from most states. The inaugural awardees include:

- ❑ California Department of Public Health
- ❑ Colorado Department of Public Health and Environment
- ❑ Connecticut Department of Public Health
- ❑ Massachusetts Department of Public Health
- ❑ Michigan Department of Health and Human Services
- ❑ North Carolina Department of Health and Human Services
- ❑ Tennessee Department of Health
- ❑ University of Pittsburgh
- ❑ Vermont Department of Health

The kick-off meeting was held at the end of September, which was followed by several months of finalizing strategic action plans. Recipients are now underway with implementation efforts.

While NCIPC is very excited about its new program, Dr. Stone also recognized some of their other important work. They are funding 10 states with near real-time surveillance of nonfatal suicide-related outcomes, such as suicide attempts, using ED data. These data, including any recognized upticks in outcomes, are disseminated to key stakeholders to inform suicide prevention in communities. Also related to data, NCIPC is working collaboratively with the Department of Defense (DoD) to link data from the NVDRS to the Department of Defense Suicide Event Report (DoDSER) to better understand suicide among active duty military, veterans, and civilians.

Also related to military, the Injury Center is funding 7 veteran-serving organizations to increase their capacity to evaluate upstream prevention programs with potential impact on suicide. NCIPC also is supporting 2 tribal nations to adapt, implement, and evaluate suicide prevention strategies from the technical package in these communities. With COVID-19 funding, the Injury Center is funding multiple projects addressing suicide, ACEs, and intimate partner violence (IPV) prevention. Together, they hope that this array of programming will help reduce the public health impact of suicide on the nation.

Suicide Research Priorities Update

Mick Ballesteros, PhD
Deputy Associate Director for Science
Division of Injury Prevention
National Center for Injury Prevention and Control

Dr. Ballesteros indicated that their goal was to assess NCIPC's suicide research efforts and update the center's priorities for suicide research. In 2015, the Injury Center identified its current self-directed violence (SDV) research priorities, which were to: 1) evaluate the effectiveness and economic efficiency of innovative and culturally relevant programs and policies to prevent SDV in the most vulnerable populations; 2) evaluate the feasibility, scalability, and economic efficiency of strategies to reduce access to lethal means in the community; and 3) improve methods to measure SDV and related risk factors to inform monitoring of trends, etiological research, and evaluation of prevention strategies.

The Office of Science developed a process to update the Injury Center's research priorities, which was used as a framework. This included setting the guiding principles and scope; establishing an internal workgroup and roles; gathering and reviewing materials, including an inventory of NCIPC projects and a landscape review of the field; synthesizing the findings; and drafting new priorities.

It terms of guiding principles and scope, it is important to keep in mind that these are research priorities. The public health model was used to discuss research and what CDC's research role should be. New priorities would apply for the next 3 to 5 years and would include intramural and extramural projects. While priorities may not be fully accomplished within 3 to 5 years, it should be possible to demonstrate progress and review completed work from 2015 to the present. Key DIP participants included Ellen Yard, Elizabeth Gaylor, Sally Thigpen, and Mick Ballesteros who did all of the day-to-day planning and initial decision-making. They created a NCIPC Workgroup that included division subject matter experts (SMEs) on suicide, economics, science, and evaluation; the Associate Directors of Science (ADS) for the Injury Center and for the Division of Violence Prevention (DVP) and the Division of Overdose Prevention (DOP); and other Injury Center leadership, including the Deputy Director and Associate Director for the Office of Strategy and Innovation (OSI).

The workgroup met monthly, reviewed progress, and gave feedback on the process, findings, and materials. They also had a lot of contract support from Guidehouse, which supported the initial thinking on this process and scope. A logic model was developed to organize this work. The process steps were included in activities and outputs in the logic model, with the updated priorities falling under short-term outcomes that hopefully will lead to intermediate and long-term outcomes of new research projects. In addition, the workgroup developed evaluation questions to focus its work and thinking. The main questions Dr. Ballesteros highlighted included:

- ❑ Has CDC done enough to address the current priorities?
- ❑ Have evidence-based interventions been adequately studied in disproportionately affected populations?
- ❑ How has the suicide prevention landscape changed in the past 5 years?
- ❑ Have emerging research issues related to suicide prevention surfaced?
- ❑ What is CDC's role?
- ❑ Which of the new priorities rises to the top for immediate focus?

To understand the intramural and extramural research conducted in the past 5 years, various inputs and data sources were used. For extramural projects, the Office of Science pulled files from the Extramural Research Program Office (ERPO) that manages external grants. Projects also were pulled from the Research Priorities Tracking System and the workgroup reviewed a list of past DVP's externally funded projects and suicide projects funded through NCIPC's Injury Control Research Centers (ICRCs). For intramural projects, again the Research Priorities

Tracking System was used and the agency's internal review system was queried. The workgroup also reviewed bibliographies from all divisions, the internal concept project development system, and an ongoing project list from the Suicide Prevention Team. A landscape review of the field conducted to better understand non-CDC work, which included discussions with internal and external SMEs and website reviews and targeted web searches on other key federal agency sites such as SAMHSA, Indian Health Service (IHS), Veterans Health Administration (VHA), and the National Institute for Mental Health (NIMH). Given that there was not ample time for a full literature review, instead they included more recent review articles on the current priorities or review papers that highlighted research needs. Lastly, they reviewed summary reports from key datasets, including: National Vital Statistics System (NVSS), NVDRS, Youth Risk Behavior Surveillance System (YRBSS), National Electronic Injury Surveillance System–All Injury Program (NEISS-AIP), National Survey on Drug Use and Health (NSDUH), and Nationwide Emergency Department Sample (NEDS).

The initial inventory from 2015-2020 included a total of 272 projects/papers, with 54 left after removing duplicate, non-suicide, and non-research items such as program work and surveillance reports. The 54 remaining projects were mapped on to the current priorities. In the few cases where a project addressed more than one priority, the priority was chosen that seemed most relevant. Of the 54 projects, 26 were extramural and 28 were intramural. For extramural projects, 10 were on effective prevention, 1 was on means access, 6 were on methods to measure, and 9 were on other areas. For intramural projects, 1 was on effective prevention, zero were on means access, 13 were on methods to measure, and 14 were on other areas. In terms of the key findings, most of the effectiveness research (2015 Priority 1) was extramural. These studies focused mainly on youth, older adults, and low-income study populations. The type of interventions varied and included approaches to enhancing connectedness, mentorship, computer-based tools, and changing behaviors. There was only 1 relevant study on lethal means access (2015 Priority 2). Almost half of the intramural research addressed new methods (2015 Priority 3). These included projects that used new data sources, such as syndromic surveillance and social media data. A few projects involved data linkage, while others used innovative analytic methods such as machine learning (ML). Among the research projects, 23 were in areas not specified in the 2015 priorities. These primarily focused on the relationships between suicide risk and factors such as connectedness, drug use, and bullying.

Based on the website reviews and other discussions, NCIPC confirmed that other federal agencies focus on areas such as clinical screening, treatment, health system-delivered interventions, and targeted populations. They heard from discussions with experts that CDC has a unique federal role as a convener, is the focal point on national goals around suicide outcomes, and has opportunities for improvement of dissemination and implementation of prevention strategies. The workgroup concluded that more work is needed on understanding risk and protective factors that can be translated into community action, evaluating prevention strategies for disproportionally affected groups, and improving getting effective interventions into the field through implementation science.

Based on these findings, the workgroup proposed the following new priorities:

- ❑ Identify risk and protective factors associated with suicide among groups at higher risk.
    a. What are the key risk factors that increase the likelihood of suicide among disproportionately affected populations?
    b. What are the key protective factors that lower the likelihood of suicide among disproportionally affected populations?
    c. What factors protect individuals who are experiencing suicidal ideation from attempting or completing suicide?

- ❑ Develop and evaluate community- and population-based approaches to suicide prevention.
    a. Which community-based programs, policies, and practices (e.g., economic policies, school-based programs) are most effective and economically efficient at preventing suicide?
    b. Which strategies that reduce access to lethal means among people at risk for suicide are most effective and accepted by the general public, and how does effectiveness vary across age or other demographic groups?
    c. Which suicide prevention strategies with the best available evidence also show evidence of addressing common risk and protective factors for other types of violence and injury (e.g., intimate partner violence, overdose/substance abuse)?
    d. What is the impact of public education, communication, and prevention messaging interventions in reducing suicide and suicide risk?
    e. What factors contribute to or inhibit successful implementation of suicide prevention strategies?

- ❑ Improve methods to measure and analyze suicide-related risk factor data to inform monitoring of trends, etiological research, and evaluation of prevention strategies.
    a. How can data quality (e.g., misclassification, lack of completeness) of existing sources be improved?
    b. What is the validity and utility of non-traditional data sources (e.g., social media, syndromic surveillance) for monitoring suicide or factors associated with suicide?
    c. What innovative analytic tools, methods, and techniques (e.g., artificial intelligence, machine learning, data visualizations) can be used to track and monitor suicide-related outcomes?
    d. How can short-to-medium term proxy measures for suicide (e.g., coping mechanisms, resilience) be measured and used in addressing suicide prevention?

Discussion Points

Dr. Kaplan noted that the National Academy of Sciences (NAS) convened a committee a couple of years ago to examine the question of rising mortality rates and socioeconomic disparities and wondered whether NCIPC has any overlapping work with them or has been involved in that committee, and/or how they intend to pursue that important area of investigation. Part of the work of that committee stems from the book and writings of Angus Deaton Anne Case on deaths of despair.[9]

Dr. Stone indicated that they are not currently engaged with that group, but thanked him for bringing it to their attention. Of course, NCIPC is very concerned with the rising rates of suicide and the burden in the middle years. They have conducted some research in the past with middle-aged men and looking at ways to better engage them. One study took place in a primary care office with the University of California-Davis and they also did some work in Michigan with Dr. Jodi Frey from Baltimore looking at ways to engage with middle-aged men through social media and other means. Financial and economic factors are certainly very important, especially given that so many people are out of work. NCIPC will continue to monitor race and suicide in

[9] https://deathsofdespair.princeton.edu/talks-writings

the NVDRS data. In the comprehensive suicide prevention program, several states are looking at suicide among the middle-aged group and recognize the need for more intervention there.

Dr. Barnes said that she did not hear any mention of prevention and she heard Native Americans mentioned a couple of times, and asked whether any of the awardees are working in Black and African American neighborhoods. The rate increased in 2019 among Black males but decreased among White males.

Dr. Stone said that she is aware of the increases in suicide with the African American community, especially among youth. She is happy to share information about the populations of focus in the comprehensive suicide prevention program. While she did not have all of those in front of her, she did know that several are looking at communities of color, including African American and Hispanic populations.

Dr. Ballesteros added that there is one project from Emory University looking at ACEs and suicide behavior among African Americans.

Regarding lethal means, **Dr. Liller** observed that gun sales have been increasing since the COVID-19 pandemic. Florida is tracking this and she wondered if that is being incorporated into NCIPC's work in terms of lethal means, gun sales, and suicide.

Dr. Stone indicated that in the comprehensive suicide prevention program, one of the strategies in the technical package is called, "Creating Protective Environments." In that strategy, there is an approach that looks at lethal means among populations at risk. That is one of the strategies with robust evidence in the field. Many, if not most, of the 9 awardees are looking at ways to reduce access to lethal means in populations at risk, including through the Gun Shop Project out of Dartmouth. This project was focused on educating gun shop owners about identifying customers and people they work with who may be at risk, such as those who purchase a firearm and small number of bullets. That is definitely part of a comprehensive approach many of these states will be working on.

Dr. Kaplan emphasized that they have been trying to prevent suicide for a very long time. The secular trends in suicide mortality have not fluctuated that much. They have remained relatively flat for the past 60 plus years despite of developments in talk therapy, pharmaceutical approaches, behavioral approaches, et cetera. He wondered whether the emphasis on trying to track at risk individuals, which he would refer to as the "needles in a haystack," has been a productive way of doing this. This is a costly very expensive approach. Even limiting access to lethal means such as guns involves identifying people who may be at risk. Perhaps they need to step back, embrace the complexity more, and start thinking about universal approaches instead of targeting at risk individuals. California has some of the strictest gun control laws and has managed to bring down a fraction of suicides involving firearms by about half of what it is in some other states.

Dr. Stone agreed that universal approaches need to be considered. The comprehensive public health approach focuses on thinking about how to reduce suicide risk by preventing people from becoming suicidal in the first place. Many of those strategies are laid out in the technical package and include things like strengthening economic support and other policies that can be implemented universally. They also are thinking about connectedness, which is especially important during COVID-19. They are hoping that the research priorities will help to identify more strategies that are effective at reducing that risk and keeping people from becoming suicidal. Identifying and responding to risk are extremely important parts of the equation.

Regarding COVID-19 and suicide, **Dr. Kaplan** indicated that he and his colleagues recently published a commentary in the *Journal of Studies on Alcohol and Drugs* (*JSAD*) that pointed out that added to the toxic mix of firearms and suicide is alcohol consumption.[10] There is evidence that alcohol sales and consumption have spiked. They found a very strong connection between alcohol consumption, at least acute alcohol use, and firearm use among suicide decedents. It is not only firearms and the stress of COVID-19, but also heavier consumption of alcohol.

Dr. Stone noted that another component of the technical package is community-based policies to reduce excessive alcohol use. Communities have focused less on this, but she agreed that it is a very important part of prevention.

Given the updated and draft research priorities and the comments made by Drs. Barnes and Kaplan, **Dr. Greenspan** asked the BSC to concentrate their discussion on whether there are still gaps in the research priorities or items that need to be refocused as this will govern the Injury Center's research for the next 3 to 5 years.

Dr. Kaplan said he thought they need to update and "widen the net" somewhat to talk about harm reduction related to suicide. "Prevention" is a word with many meanings and he was not exactly sure that they were talking about preventing suicide or what they meant by that. There is mounting evidence for the need for greater emphasis on universal approaches. There also is the question of "silent suicide" that his colleague Dr. Steven Stack calls them. Many individuals die based on NVDRS analysis who do not have the standard psychiatric markers of suicidality. There is a lot that is unknown, and he thinks they need to re-embrace complexity in the understanding of this tragedy. There are new opportunities with gun research. He still calls firearm suicides the "hidden epidemic." A lot more needs to be addressed and updated.

Dr. Barnes thought there seemed to be equal emphasis on risk factors and protective factors, but she thinks stronger emphasis should be placed on protective factors. They talk too much about risk factors, which have not changed in 25 years. Strengthening the protective factors can nullify the risk factors. She was reading a report that was written in 1996 on the risk factors among African American and Black communities and they were the same as today. It was almost as if the article was written today. If they have not changed in 25 years, they should place more emphasis on protective factors, especially for youth when there needs to be a strong emphasis on the social fabric, connectedness, self-esteem, and strengthening emotional skills.

[10] A Reply to Monteiro et al.'s (2020) 'Alcohol Policy and Coronavirus: An Open Research Agenda' Mark S. Kaplan, William C. Kerr, Bentson H. McFarland, Kara Bensley, Raul Caetano, Norman Giesbrecht, Shannon M. Monnat, and Kurt B. Nolte; *Journal of Studies on Alcohol and Drugs* 2020 81:5, 687-688; https://www.jsad.com/doi/full/10.15288/jsad.2020.81.687

Dr. Ballesteros pointed out that they were talking about research priorities specifically about risk and protective factors and the lack of emphasis on the lack of protective factors in the past. In their attempt to address that, they included a research question specifically about protective factors rather than just saying “risk and protective” factors together. There might be other ways to emphasize that more, perhaps in the accompanying text that they will write with this.

Dr. Kaplan observed that another way of putting this pertains to why some communities thrive, and others do not. They need to approach this in a more balanced way. Most of the research on suicidality focuses on pathology as opposed to the protective factors. Another example of that regards the role health-related quality of life in suicide risk in older adulthood. There has not been enough research in this area, which could be another area of focus to determine the much broader factors that are protective of older individuals—men in particular. There also has not been sufficient focus on gender-specificity. Suicide mortality is an overwhelming male phenomenon. Yet, the prevention of suicide has not followed where the evidence seems to be pointing..

Dr. Floyd asked whether NCIPC is assessing ways to study how best to engage and educate primary care clinicians to help with depression screening and suicide prevention. It strikes him as a primary care clinician that what they are doing right now is ineffective.

Dr. Stone agreed that primary care is a great venue to help identify and support people who may be at risk and who understand quality of life issues and so forth. NCIPC conducted a controlled trial with the University of California-Davis to assess how to better engage primary care physicians in suicide prevention. In that study, primary care physicians were recruited and there was a tremendous response from them about wanting to know how to better support their patients. That was gratifying to see. The difficulty in that study was that it was hard to recruit the men who were the sample to participate. She agreed that more attention to this issue is important and there have been some studies in the past about the effectiveness about screening and engaging men in primary care.

Dr. Kaplan added that he and his colleagues conducted a survey of primary care providers some years ago among primary care providers working with older patients in particular. They found fewer than 50% of primary care physicians probe for firearm availability among their at-risk depressed or suicidal older patients. Something as simple as this one question alone asked the family and the patient could reduce the harm.
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Focusing on youth suicide prevention and Dr. Barnes’ comments about creating environments that are affirming, **Dr. Frye** wondered how much research or prevention work is being done in schools specifically related to creating affirming environments for LGBTQAI+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+) individuals, as well as environments that are not frightening or threatening to students of color (e.g., presence of public safety police officers on K-12 school campuses and buildings) and culturally competent instruction year-round and not just a week here or there. That is, creating environments that allow children to thrive and affirm their humanity and its connection to self-harm.

Dr. Stone said that certainly they have been very concerned about increases in youth suicide, particularly during COVID-19 with the level of stress and anxiety, especially among youth. Some of the best suicide prevent evidence has been reported in school programs. The Good Behavior Game (GBG) focuses on social/emotional awareness, coping and problem-solving skills, et cetera for very young children in first and second grade. Youth Aware of Mental health (YAM) is another program. Sources of Strength is a program that has been widely implemented to help youth understand that it is okay and is a sign of strength to reach out to a trusted adult when having a problem. Scaling up more of these program is very important to address youth suicide. Regarding LGBTQ, there has been some evidence to suggest that when schools have programs to address LGBTQ youth, they actually impact favorably for whole school community. Having

openness and tolerance can improve the quality of life for everyone in the community. NCIPC will continue to test these programs and seek out new evidence.

Dr. Barnes added that there is definitely a need to have more wellness-type circles for young children, especially in middle school where they develop their social and coping skills. There are not enough of these programs.

Emphasizing that African American youth have shown an increase in cases of suicide in the latest data, **Dr. Liller** asked whether this population would be a particular focus of all of this work.

Dr. Stone reiterated that some of the comprehensive suicide prevention awards went to communities that are interested in suicide prevention among African American and Hispanic youth. They look forward to being able to share what works in those communities.

Dr. Houry added that there is some ACEs work in different communities, some of which is focused specifically on suicide among men and boys of color.

Workgroup Updates

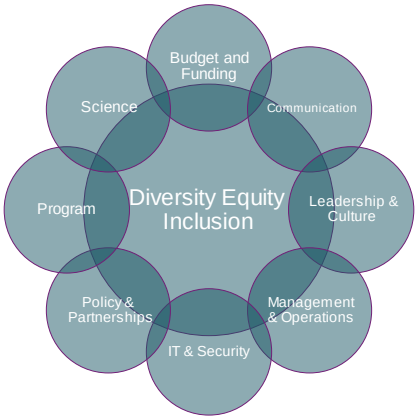
NCIPC Diversity, Equity, and Inclusion (DEI) Workgroup

Derrick W. Gervin, PhD, MSW
Chair, NCIPC Diversity, Equity, Inclusion Workgroup
Acting Director for Extramural Research
National Center for Injury Prevention and Control

Dr. Gervin said that the DEI Workgroup was honored to have an opportunity to update the BSC on its activities over the past few months. It is no surprise that the inequities associated with the coronavirus pandemic, combined with protests for racial justice and civil rights, renewed discussions on racism in the US. While local and state leaders declared racism a public health issue, NCIPC heard directly from their recipients, partners, and staff members who challenged them to take a closer look at every aspect of their work from scientific products and grants to how they interact with each other in the workplace. During the August 20, 2020 BSC meeting, they discussed the importance of creating diverse, equitable, and inclusive environments within the NCIPC workplace and across the programs they support. The group also discussed existing and emerging projects focused on addressing racial and health inequities. During this session, Dr. Gervin shared updates and progress made to advance the Injury Center's commitment to diversity, equity, and inclusion.

A major step following the last BSC meeting was the announcement of the DEI Workgroup in early September 2020. The purpose of the workgroup is to strengthen NCIPC's culture of diversity, equity, belonging, and inclusion. Approximately 14 volunteers from across the Injury Center were selected to participate in the workgroup. Many of the workgroup members lead and participate in workgroups and organizations across the Injury Center and CDC that also touch on diversity and equity, such as the Race and Violence workgroup in DVP, the Committee on Diversity (COD), and Blacks in Government (BIG). Dr. Gervin also thanked and acknowledged the workgroup members who all stayed on to support this effort through deployment, details, and while doing their full-time jobs. This is a very dedicated group of individuals.

One of the early products developed by the workgroup was this diagram of the NCIPC Domains of Diversity, Equity & Inclusion which highlights key areas where opportunities for DEI work exists:



Given all of the potential areas of focus, this model helped to prioritize the group's focus on activities that could positively impact NCIPC staff, while also keeping in mind the potential for other areas to impact staff and the Injury Center's overall work. There are many activities within each of the domains listed, so Dr. Gervin highlighted a few as examples. Starting at the top, *Budget & Funding* includes activities like funding contracts and extramural research awards. The *Communications* domain includes internal and external communication, and how topic areas are framed. The domain of *Leadership and Culture* includes things like organizational culture and environment, as well as strategic planning. *Management and Operations* includes activities like mentoring, promotions, and recruitment and hiring practices. *Program* includes the development and implementation of NOFOs and provides technical assistance (TA) to recipients. The domain of *Science* includes activities like how NCIPC develops and clears publications and products, and how they form the NCIPC research agenda.

The workplan for the DEI workgroup was organized into 3 primary phases focused on discovery, engagement, and implementation. It is anticipated that these activities will take them into the Spring of 2021. Looking at the months since the formation of the workgroup, there have been numerous activities and accomplishments during the discovery or planning phase. Although the group got off to a strong start in September, quickly developing the equity domains, there were some pauses and delays as a result of the Executive Orders that came out in late September. Dr. Gervin joined the workgroup in early October and assisted in developing the work plan. In November, they made a conscious decision to narrow the work to focus primarily on the environmental scan and science/research activities that they felt were most aligned with the BSC discussion in August 2020.

As the DEI workgroup activities were getting started, progress was made in other areas around the Injury Center. In October, NCIPC's Office of Program Management and Operations (OPMO) released guidance on hiring and interview panels, which incorporates diversity in both resume review and interview panels to better ensure equity in candidate selection practices. The updated guidance received over 100 comments and suggestions from around the Injury Center and was vetted by Equal Employment Opportunity (EEO), Human Resources Office (HRO), and Office of Minority Health and Health Equity (OMHHE).

Using FY20 discretionary funds, NCIPC was able to fund a cooperative agreement with American Public Health Association (APHA) focused on increasing minority researchers in injury and violence prevention where the purpose of the project is to increase the pool of under-represented investigators from Historical Black Colleges and Universities (HBCUs), Minority-Servicing Institutions (MSIs), and majority schools to enhance research and prevention efforts in addressing the disproportionate impact of injury and violence in diverse communities and populations. There are also some exciting FY21 discretionary projects being planned that they hope to share updates on in the future, as well as the ongoing analysis of previous awards that involves work initiated by DVP's Race and Violence Workgroup and described in the last BSC meeting.

Regarding NCIPC's research NOFOs, the Injury Center recently amended language across 6 NOFOs to include guidance for applicants to address the social and structural community conditions that contribute to health inequities. The Injury Center also has had promising discussions with the Office of Grants Services (OGS) and the Office of General Council (OGC) about emphasizing equity and inclusion in NCIPC's non-targeted funding mechanisms. Dr. Gervin noted that they would hear more later about NCIPC's research NOFOs from Dr. Marci Wright who leads the Research Grants Management Team for ERPO. Although there are various activities occurring around the Injury Center, they hope to find ways to connect these projects and activities to the DEI workplan. The goal is to use data and scientific knowledge to guide the implementation of activities.

In terms of next steps, NCIPC wants to ensure that their its work is aligned with Dr. Walensky's vision and goals for the agency. They also want to revisit the broader workplan and wish list of activities that they developed in September. Although they were not able to move forward with the contract they started with, the Injury Center has recently contracted with a company to resume the NCIPC climate assessment activities that were initially envisioned. The new contractor also will work closely with the DEI workgroup and will join regular meetings. The workgroup felt that it was very important to keep Injury Center staff a priority. Much of this focus stems from wanting to ensure that activities result in very tangible and immediate outcomes that have direct impact. Therefore, this focus will continue. Ultimately, they want to develop and implement recommendations that not only align with the purpose of strengthening a culture of diversity, equity, belonginess and inclusion, but also that support the Injury Center's priorities.

In closing, Dr. Gervin posed the following questions for discussion:

- ❑ How do we engage colleagues in DEI work on a deeper level (i.e., having a personal investment)?
- ❑ What are ways we can leverage similar work in the agency?
- ❑ How do we create long-term, sustainable change?
- ❑ Are there other BSC priorities that should be considered?

Discussion Points

Dr. Schwebel emphasized the importance of this topic for everyone in this country right now. He encouraged the DEI workgroup to remember to consider all aspects of diversity. The focus on race, ethnicity, and gender is obviously very important and should be a priority. However, consideration also should be given to diversity in terms of sexual orientation, sexual

preferences, religious preferences and practices, and differences in political opinion. Differences in political opinion is often lost in the discussion, but it is important in this country right now. There are many differences, all of which should be respected.

Dr. Houry added that she could not speak to political differences the DEI workgroup may represent, given that they did not ask that question when people applied. They certainly included race, ethnicity, gender, sexual orientation, and disabilities. A lot of it is truly invisible, but they did try to include as broad a group as possible to guide the Injury Center.

Dr. Cunningham thought it was great to engage in the first discovery to determine where the problems are and to then think about how to move forward. They also must make sure to focus on representation in terms of not only diversity, but also in terms of who is under-represented in funding and the work being done. She liked the idea of weaving into the existing NOFOs some content area that would address diversity, but it also is extremely important to have some initiatives that will bring ethnic youth to the table. It is important to have the content within the NOFOs, but also specific initiatives that will bring new voices to the table who have different and important perspectives.

Dr. Greenspan pointed out that the major purpose of the cooperative agreement with the APHA is to ensure greater diversity in who applies for NCIPC grants, and to provide training to improve improve applications to ensure greater diversity in all of the Injury Center's funding mechanisms.

Dr. Gervin added that they have had some very promising discussions with the OGC and OGS about other research NOFOs in which they really want to have a much larger footprint in terms of how they fund a diverse population of researchers. They think this will happen based on the initial discussions they have had.

Dr. Kaplan recalled that during the August 2020 BSC meeting they discussed some of these issues. In addition to identifying and facilitating a grantsmanship process, it is essential to make sure that grantees succeed in disseminating their findings and making sure that their research has an impact. Not only should there be help in seeking grants, but also there should be assistance in sustaining those accomplishments.

Dr. Gervin said that he did not mention one of the examples because the conversation is still so early, but there is funding out of the OSI for a Health Equity Resource Center where they hope to provide much more support in this area to the field and perhaps even TA.

Dr. Cunningham expressed interest in knowing what else is happening across the agency so that the efforts within NCIPC are not just local. This is a crosscutting issue so it is important to determine how the work within the Injury Center will align with the broader landscape across the agency and in other centers and divisions.

Dr. Houry indicated that she is a representative on the agency-wide committee and that she was pleased to say that NCIPC is one of the centers that has been highlighted a lot for best practices and lessons learned, including the upcoming diversity assessment and resiliency sessions that were done that were modeled and used by other centers and many of the employee organizations. A lot of communication has been coming from the new CDC Director, so a lot of this is still to be determined. However, they have been asked to provide updates on its diversity activities and communities of practice to their Deputy Directors so they can look across the agency. All senior leaders will be piloting some new diversity training on microaggression and unconscious bias before it is rolled out to the next level of leaders at CDC to get feedback on it. Then Center Directors and above also will be going through some active listening, critical conversations training, et cetera as well. That is agency-wide. There also are some new hiring efforts agency-wide as well.

Dr. Greenspan added that all of the ADS in the centers belong to an Excellence in Science Committee that now has a workgroup on health equity and diversity. One of the things being done in terms of improving the science and the issue of health equity is the establishment of a fellowship program among people within CDC to be able to focus on health equity work. That is very much being done in alignment with the OMHHE. A health equity award is going to be added. There also is a lot of discussion underway about how to improve equity in research and representation.

Dr. Frye indicated that she has been involved in a lot of these activities and working groups at various institutions over 20 to 25 years. For example, she is currently serving on the National Academy of Sciences, Engineering, and Medicine (NASEM) Action Collaborative to Prevent Sexual Harassment, Gender Harassment, and Misconduct in Higher Education. She also is a Diversity Faculty Senate Liaison to the Executive Committee, and her own school's Inclusive Excellence Council. Across all of these experiences, she has noted that a couple of things are actually effective and a lot of things are ineffective. Changing policies where there is accountability involved is effective. For example, if a NOFO requires that someone who is studying a population has a Bachelor's Degree related to that population. For instance, someone studying an African American or Black population should have a Bachelor's Degree in African American studies and various demonstrations of expertise in order to study a specific population. Various accrediting agencies are now demanding competencies and characterizing evidence of gender harassment or misconduct as scientific misconduct and disqualifying people from getting grants, recognition, et cetera. Those kinds of policies that have impact on scientists or institutions are the ones that actually work. Collecting some evidence about that and putting it all in one place is very helpful. She noticed that when the Executive Order came out, many institutions and individuals were thrilled to be able to drop that kind of work and hide behind that order. She wondered whether NCIPC noticed this, how that played out, and how that could be a discussion point for going into the deeper work and the personal investment.

Dr. Schwebel acknowledged Dr. Greenspan's comments and the importance of building the research perspective. The first question about engaging colleagues in DEI's work on a deeper level is very challenging. This takes a lot of investment, time, and effort and will not happen quickly. His suggestion is to celebrate the diversity they have and find ways to do that. He is confident that there is some type of celebration for the holiday season in December and that is appropriate. For instance, the previous week was Luner New Year. He suspects there are people in NCIPC who celebrate that holiday. Perhaps that is a way to acknowledge that. It is not easy, but he encouraged continued effort and work because it is so important for society.

In terms of the discussions about specific efforts in funding to build the diversity of investigators, **Dr. Liller** asked whether there has been any talk about making new investigator awards. She recalled discussions in previous BSC meetings about how important it is to get that first grant, which can snowball to the next grant.

Dr. Gervin indicated that this is one of the awards they discussed with the OGC and OGS and they did not get any pushback about being able to do that, so they are hoping to try to focus on K01 new investigator awards.

Dr. Wright added that the extramural research program is delighted to share that following the discussions with the BSC last summer, they were able to bring online 2 important secondary review considerations for the NCIPC research NOFOs this year. Every NCIPC research NOFO has a second level program review consideration for institutions from or collaborating with MSIs. They also brought online considerations for early stage investigators. These are the NIH-designated investigators with 10 years or less of post-graduate research experience who also have not yet earned an R01. The hope is that in combination with the consideration for MSIs, the consideration for early stage investigators will allow them to reach through by proxy to minority, under-represented populations as Principal Investigators (PIs). In the meantime, they have not yet been able to specifically say that they are considering minority PIs at secondary review because they did not have a process by which they could pull in that type of demographic information and keep that firewalled from peer review. However, as Dr. Gervin stated, they successfully talked with OGC and OGS in order to bring that online. They have agreed to test that with a K01 new investigator NOFO for FY22.

Dr. Cunningham reiterated that thinking about a long-term sustainable change requires funding people at that early stage, particularly racial and ethnic minorities, to work with these populations. This has been done at CDC. She was the recipient of this in the Minority AIDS Research Initiative in another center, which changed her career trajectory. She has mentored others who have received that award and it changed their career trajectory, and it has created a cohort of people who have gone on to be successful and have focused on the communities which they come from to address their issues. This can make serious long-term changes, create leaders to address these specific areas in communities, and bring in new perspectives.

Dr. Greenspan pointed out that the NCIPC ERPO does have that as primary goal and is in active discussions to determine how to bring in more minority researchers. They do have K01s in the DVP and she would like to consider how to broaden that. She agreed that whenever in the past they have offered early investigator awards, the investigators have done a lot with those investments and gone on to do great things despite the fact that they are relatively small awards.

Dr. Frye emphasized the importance of building in policies with accountability and training reviewers to recognize competence and excellence when they see it and to understand their own biases.

BSC Opioid Workgroup

Chinazo Cunningham, MD, MS
Chair, NCIPC Opioid Workgroup
Division of General Internal Medicine
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Dr. Cunningham reminded everyone that the Opioid Workgroup was established in July 2020 to provide expert input and observation on the update of the *CDC Guideline for Prescribing Opioids for Chronic Pain*. The workgroup membership represents a wide range of those with lived experiences and expertise such as patients who experience pain, caregivers of patients who experience pain, and clinical specialists who engage in treating people with chronic or acute pain such as dentists, primary care providers, surgeons, and other clinical specialties.

Thus far, the workgroup has convened twice. The first meeting was in October 2020 and that included a review of the Opioid Workgroup terms of reference and the logistics of the workgroup operations. They also received a presentation for the rationale of the 2016 guideline creation highlighting the recommendations and describing the results following the implementation of the guideline. The second meeting in November 2020 included a review of the processes used to gain stakeholder perspective and insight and a description of its emerging themes. That came from two *Federal Register Notices*. One was for "Management of Acute and Chronic Pain: Request for Comments" and the second was "Management of Acute and Chronic Pain: Opportunities for Stakeholder Engagement."

An upcoming Opioid Workgroup meeting will focus on the overview of GRADE (Grading of Recommendation Assessment, Development, and Evaluation) that will focus on determining the strength of the recommendations and grading the quality of the evidence. This work is to prepare them for reviewing the draft guideline, which is anticipated to occur in March 2021. The workgroup will report its observations back to the full BSC in the Summer of 2021. A *Federal Register Notice* will be published to solicit comments on the draft guideline by the end of the calendar year of 2021. As a reminder, the documents and the products that are developed by the workgroup are made public only after presentations to the full BSC.

Firearm-Related Violence and Injury Prevention

History of DVP's Firearm Injury Research

James A. Mercy, PhD
Director, Division of Violence Prevention
National Center for Injury Control and Prevention

Dr. Mercy indicated that in December 2019, NIH and CDC each received $12.5 million dollars to undertake research on firearm injury prevention. This marked the first time in nearly 25 years that CDC had funding dedicated to understanding firearm injury prevention. To help explain why CDC has not been able to fund firearm research for 25 years, he presented on the historical context of gun ownership and how it plays into what happened 25 years ago to CDC, the history of CDC's surveillance and research activities back then and how it has proven to be a strong foundation for many of the current efforts, and the challenges and opportunities the agency faces going forward.

For the past 50 or more years, there has been a steady increase in the proportion of people living in urban areas in the US. Associated with that increase, there has been a steady decline in the proportion of households containing at least 1 gun from about 47% in 1973 to about 34% in 2018. There has been a substantial increase in the number of guns possessed in the US. What has happened is that these guns are concentrated in the hands of a fewer number of households over time. There also has been a steady decline in the proportion of respondents who report hunting from about 43% in 1977 to 17% in 2018. These demographic and behavioral shifts were associated with a profound shift in the way the gun industry marketed its products. In order to survive and expand its market, the gun industry began increasingly marketing guns for self-defense. It is important to bear this in mind in consideration of history.

In terms of the rates of firearm and non-firearm homicide in the US from 1981-2018, firearm homicide rates have by and large declined since their peak during the crack epidemic of the early 1990s. However, beginning in about 2014, firearm homicide rates have increased. During 2020, there are numerous reports of increases in homicide rates across the country from 20% to 40%. There has been a substantial change over the past year. Similarly, firearm and non-firearm suicide rates in the US from 1981-2018 converged around 2006-2007 and continue on a steady upward trend until 2018. These contrasting trends in firearm homicide and suicide account for the increasing proportion of all firearm deaths that are accounted for by suicide.

Reflecting on some of CDC's firearm surveillance and research activities, Dr. Mercy recalled that the period between 1985-1995 was a "Golden Age" for firearm injury and research. CDC was building some foundational data systems and supporting very exciting research. The extramural research grant program within NCIPC began in 1985. CDC's strategy for addressing firearm injuries in the 1980s and 1990s was outlined in an *NEJM* in 1988.[11] The goals were to: 1) reframe the public debate, perhaps somewhat naïvely, from an ideological basis to a scientific one; 2) establish a national firearm injury surveillance system for non-fatal and fatal injuries; and 3) develop a sound scientific basis for preventing firearm injuries to include undertaking research to better understand patterns of firearm acquisition/use and injury causes, evaluating policies and interventions, and assessing technological innovations. This strategy is almost the same as the strategy being pursued with the current funding.

A number of injury surveillance projects began during those years. In 1990, questions were incorporated in the Youth Risk Behavior Survey (YRBS) on weapon and gun carrying. Those data continue to be collected in addition to some other questions that have been added. The Nonfatal Firearm Injury Surveillance Study (NFISS) was established in 1993, which allowed CDC to provide an estimate for the first time of the number of non-fatal firearm injuries treated in EDs in the US. This system is based on the Consumer Product Safety Commission (CPSC) National Electronic Injury Surveillance System (NEISS), which led to the development of the NEISS All Injury Program (NEISS-AIP) available through the Web-based Injury Statistics Query and Reporting System (WISQARS™). NCIPC also performed several surveys on its own, including the Injury Control and Risk of Injury Survey (ICARIS) that allowed them to conduct some important research on firearm access, storage, carriage, and protective use in 1994, 2001-2003, and 2007-2008.

[11] Mercy JA, Houk V. Firearm injuries: A call for science. NEJM 1988; 319(19):1283-1284

They also began incorporating a module into the Behavioral Risk Factor Surveillance System (BRFSS) with firearm-related questions on access, storage, and defensive use. In the early 2000s, a subset of questions from this module was incorporated in the core survey of BRFSS which enables these data to be collected across all states involved in the BRFSS. Though this ended in 2004, an optional module has been included for states on firearm safety practices that was used in 2017 and will be available again in 2021. The NVDRS began in the early 2000s. It is important to note that NVDRS was originally thought to be a firearm mortality surveillance system patterned on the National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS). Given what was transpiring at the time, the NVDRS was focused on all violent deaths, homicides, and suicides. Between 1994-1998, some states were funded to conduct firearm injury surveillance projects. The states included Colorado, Maryland, Massachusetts, Missouri, Oklahoma, Washington, and Wisconsin. The states explored a variety of options including media sources, EDs, and surveys to explore this issue. Some of the systems established in those states back then remain in effect currently.

In addition to supporting the firearm surveillance activities and strengthening data around firearms, CDC funded a lot of research in those early days. One of the key questions that many of those studies addressed was, “Does having a gun increase the risk of injury or will it protect me?” That is a fundamental question that is still important and that includes many dimensions that need to be explored. This research question was running right into the shift in the gun industry’s marketing strategy toward self-defense. One of the studies in the first cohort of R01 studies funded through NCIPC’s extramural grant program was a study conducted by Dr. Arthur Kellerman focused on violent death in the home in relation to gun ownership. This study found that those households with a gun were at almost 5 times greater risk for one of the household members to commit suicide[12] and at almost 3 times greater risk for one of the household members to experience homicide[13]. This fundamentally important study has been replicated at least 7 times since the original publication, with the findings confirmed. Dr. Mercy thinks this is a seminal study in the injury field that is comparable in chronic disease to the early studies of cigarette smoking and lung cancer. This is just one of a host of studies NCIPC was funding through its extramural grant program at the time. NCIPC also was conducting intramural firearm injury research on a broad range of topics including the basic epidemiology of firearm injuries, lethality of firearm injuries, international comparisons, defensive gun use, and firearm storage practices. The international comparisons done in the 1990s are used to this day to show that the US has much higher firearm death rates than other comparable high-income countries.

Moving on to the challenges and opportunities, as this research came to light, many questions were raised from people outside of CDC about the research the agency was supporting and conducting. These included accusing CDC of being biased against personal firearms ownership, duplicating efforts within federal government, using funds for political advocacy, engaging in junk science, and leadership in injury being politically motivated. There also were personal attacks on several people at CDC working on this topic at the time. In the 1990s, control of the House of Representatives changed to Republican control. When that happened, the Appropriations Committee of the House threatened to eliminate the funding for the CDC Injury Center. Long story short, the Democrats and Republicans came up with a compromise that involved transferring the $2.6 million being spent on firearm injury research at the time to traumatic brain injury (TBI) work within the Injury Center. Beginning in FY1997, language was introduced stating that, “None of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention, may be used to advocate or promote gun control.” This remains in the appropriations language to this day. This same language was introduced into the appropriations language for other HHS agencies in FY2012. It is important to note that this language does not prohibit CDC or other HHS agencies from collecting data or conducting public health research. It still created an incredible chill among leadership within CDC about the risk of being too up front in addressing firearm injuries. The agency did continue to do some

[12] Kellermann AL et al. Suicide in the home in relation to gun ownership. N Engl J Med 1992; 327:467-472.

[13] Kellermann AL et al. Gun ownership as a risk factor for homicide in the home. N Engl J Med 1993; 329:1064-1091.

intramural work on firearm injuries in the intervening years, but it was much more limited and the work largely dried up.

This image shows President Obama signing the 23 executive actions designed to reduce gun violence reflected in his *Now is the Time* plan:

This came shortly after the Newtown Shootings of 2012. When speaking about his *Now is the Time* plan, President Obama said, “We won’t be able to stop every violent act, but if there is even one thing that we can do to prevent any of these events, we have a deep obligation, all of us, to try.”

One of the products that came out of those efforts and President Obama’s advocacy for this work was that CDC used funding from foundations and other outside organizations to support the Institute of Medicine (IOM) and National Research Council (NRC) to create an agenda of priorities for public health research to address firearm injury-related violence. This document, *Priorities for Research to Reduce the Threat of Firearm-Related Violence*.[14] is still used to this day and is reflected in NCIPC’s NOFOs on firearm injuries, and has helped shape some of the research questions on which NCIPC focuses. The need for action grew over this period, particularly in response to the state of mass shootings that have occurred. These events, along with changes in Congress, resulted in the appropriation of the $12.5 million to CDC in December 2019.

[14] *Priorities for Research to Reduce the Threat of Firearm-Related Violence*; Authors: National Research Council, Division of Behavioral and Social Sciences and Education, Committee on Law and Justice, Institute of Medicine, Executive Office, Institute of Medicine, Committee on Priorities for a Public Health Research Agenda to Reduce the Threat of Firearm-Related Violence; Editors: Patrick W. Kelley, Margaret A. McCoy, Arlene F. Lee, Bruce M. Altevogt, Alan I. Leshner; *National Academies Press*, 2013; ISBN 0309284414, 9780309284417; 120 pages.

Firearm-Related Violence and Injury Prevention Research Grants

LCDR Marcienne Wright, PhD
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Dr. Wright, in partnership with the DVP, shared an overview of FY20 research awards funded under NCIPC's firearm-related violence and injury prevention R01 and K01 grant mechanisms. As noted, Congress appropriated $12.5 million to CDC to support research on firearm injury and mortality prevention and asked the agency to take a comprehensive approach in examining the underlying causes and evidence-based approaches to prevent firearm injury, deaths, and crime.

To achieve that goal, NCIPC issued 2 research announcements. One was for R01 investigator-initiated research to understand and prevent firearm-related injuries, deaths, and crime. It called for etiologic research to improve understanding and inform the development of interventions; and efficacy/effectiveness research of strategies to keep individuals, families, schools, and communities safe from firearm-related injuries, deaths, and crime. All types of firearm injury were included in the scope of the announcement (e.g., firearm homicides/assaults, firearm suicides/self-harm, unintentional firearm deaths and injuries, and mass shootings). The announcement offered 2 funding options that included 2-year projects for up to $350,000 per year for which 7 awards were made, and 3-year projects for up to $650,000 per year for which 9 awards were made. For this announcement, 69 applications were received, 62 scored in peer review, and 16 awarded totaling approximately $7.84 million in FY20 funds issued for the extramural program.

For the 9 awards issued to grantees conducting etiologic research, award recipients are focusing on understanding risk and protective factors across a range of topics, including risk and protective factors underlying gun-related attitudes, behaviors, access, gun carrying, and safety practices among youth and adults; those related to different forms of firearm-related injury; and direct and indirect neighborhood-level exposures and related demographic, temporal, social and economic factors.

For 5 awards issued to grantees conducting efficacy/effectiveness research, award recipients are conducting studies that are rigorously evaluating a range of prevention approaches, including hospital-based interventions to prevent future victimization and perpetration of firearm violence; bystander approaches; crisis intervention approaches (e.g., gun shop projects, which are community-driven suicide prevention partnerships between the firearms community and local public health and community health agencies aimed at temporarily reducing access to firearms during times of crisis); and firearm safety interventions to reduce unintentional injuries among children. Additionally, 2 awards were issued to grantees pursuing a combination of etiologic and efficacy/effectiveness research.

NICPC's R01 research awards reflect research conducted across the US, including recipient institutions from 11 states. The research varies in focus. Some studies are national in scope, while others are focused on states and local areas. Within states, many focus on urban areas, but a few specifically focus on rural areas. With respect to study populations, some focus on the general population and others focus specifically on children, youth, or adults and Active Duty/Veteran populations. Some focus on universal populations, while others focus on groups experiencing disproportionate impact or elevated risk for firearm injury.
Although the R01 announcement did not specifically focus on addressing health disparities or SDOH, Dr. Wright highlighted 2 projects that are addressing racial and ethnic health disparities including one that is examining the impact of parental use of firearms on children's attitudes with a focus on racial and ethnic disparities, and another that is determining the efficacy of a hospital-based intervention program in reducing risky firearm behavior and carriage in high-risk youth with a history of firearm carriage. One project is addressing SDOH across populations by exploring the population prevalence and consequences of youths' exposure to community gun

violence and identifying associated risk and protective factors using national secondary data. This study intends to address the disparate impact of firearm-related violence on communities of color.

NCIPC is committed to supporting new investigator awards that provide a mentored research experience to foster career development in independent research. For the second announcement, the Injury Center issued an amendment to its FY20 K01 New Investigator mechanism, which was focused on violence impacting children and youth, to also include an examination of firearm-related behavior, injuries, deaths, and crime among children and youth. Of the 2 firearm-related awards, one will examine neighborhood-level exposures and how they work together to impact firearm violence and the other will gather formative and survey data to develop an intervention to reduce threats expressed via social media that have been implicated in firearm-related violence and other forms of youth violence.

In terms of next steps, NCIPC will hold a virtual reverse site visit for all 18 awards in Fall 2021. The site visits will provide opportunities for break-out group "communities of practice" to discuss their preliminary findings and opportunities for data strengthening. All 18 firearm-related violence and injury prevention awards are summarized on DVP's webpage.[15]

Discussion Points

Dr. Kaplan said he was delighted to see that firearm-related research is now funded. He found the history of this to be fascinating beccause Dickey Amendment is still in place, there is the Second Amendment, and there is opposition to funding gun violence research. He wondered how to arrive at a more stable funding stream that may resist the temptation to undo the progress of the last two years. It seems fragile, given that Congress could change hands two years from now, which would be the end of it. The future still looks grim to him, to say the least.

Dr. Mercy said that first, we have to exhibit the utmost transparency in the way this research is funded, carried out, and shared. We have to be as objective as possible in the work that they do and the way we ask the questions and conduct the research. He thinks that we can pursue firearm injury prevention at the same time that we protect the individual rights of legitimate gun owners in the US. It is not antithetical that one can approach prevention and simultaneously protect gun rights.

Dr. Kaplan asked if it is about science. They could run into trouble if they say that science will rein in this case. They have seen this happen in other areas of public health practice. Simply being the purveyors of rationale scientific evidence alone is not going to work, in his opinion. There is a Second Amendment, and there are science deniers no matter what is produced. The science already exists. It is known based on ecological and case-control studies that more guns translate into more morbidity and mortality. He wondered what else they possibly could do other than produce more science and whether that is the answer.
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Dr. Mercy said that CDC's role lies at the interface between science and prevention. There certainly is a role for many organizations across the country to pursue other objectives in this space. He also does not think the science is out on all of the key questions. The effectiveness of many policies is unknown and more information is needed. A fair number of important research questions remain to be answered.

Dr. Kaplan pointed out that how states perform gun control policies is known from the Annual Scorecard. The Giffords Law Center to Prevent Gun Violence (Giffords Law Center) ranks California at the top of that list. He thinks it is a mistake to believe that it is an isolated policy that matters. It is the accumulation of these policies and the normative changes in those states that

[15] https://www.cdc.gov/violenceprevention/firearms

matter most. As a whole, those policies have reduced the rates of gun violence in California and some other states that have done well.

Dr. Mercy added that California in particular has had a lot of research conducted by key researchers, such as Garen J. Wintemute who helped inform the State policy agenda.

Dr. Barnes observed that there has always been a time when suicide rates by firearm were much higher than firearm homicides, which is still the case.

Dr. Mercy indicated that this gap has been growing as suicide rates have increased dramatically over the past 15 to 20 years. About 50% of suicides and about 75% of homicides are committed with firearms.

Dr. Franklin wondered how they could ensure that the science cannot be dismissed. The COVID-19 pandemic has been dismissed at all levels of government. He agreed that there is a need to sustain progress and move forward, but this tends to shift back and forth with administration changes.

Dr. Mercy agreed that these were great questions and said that he did not pretend to have all of the answers about how to do that. What CDC can do is maintain integrity and transparency and show through the research that there can be success in reducing firearm injuries. He emphasized that Congress charged CDC to conduct research—not with applying the results of the research. That is quite different from other areas of work within the Injury Center and throughout CDC. Ultimately, we need to be able to demonstrate that what the science suggests can actually make a difference in communities, counties, states, and cities. To him, that is the biggest challenge.

Dr. Kaplan pointed out that while over 50% of suicides involve firearms, the picture looks even grimmer than that in some states. For instance, about 90% of all deaths among older men who die by suicide in Mississippi involve firearms. There is a lot of variability across the country, which is highly correlated with the community-level availability of guns. He did not mean to suggest that science does not matter, but he thought that the debate about gun violence is often driven more by politics than sound science. Therefore, he believes they need to be more creative in how they approach this issue. What happened to Arthur Kellermann can happen again.

Dr. Mercy agreed and emphasized that this is why it is important to remember this history and learn from it.

Dr. Frye thought Dr. Mercy left out some incredibly important and germinal research that involved firearms from Dr. Jacquelyn Campbell's multi-site study of IPV femicide and predictors of IPV femicide. That research was able to be conducted because femicide systems had been set up in multiple cities throughout the US using funding Dr. Mercy described early. That was the case in New York City (NYC) where they abstracted data from every Medical Examiner record of female homicides from 1990-1999 manually. Those data were not computerized, so they abstracted all of it and mapped and charted over time. Dr. Campbell's study identified that access to a firearm was an independent predictor for IPV femicide among battered women. They had controls in the community comprised of whom who should have died but did not. That led to policy precedented case law statutes all over the country limiting access to firearms for batterers. That made a very big impact that needs to be highlighted. That reminded her that IPV often gets overlooked and not paid attention to. In using those data that stemmed from all of the programs Dr. Mercy described, they learned that IPV against women is different from general violence. Therefore, her question pertained to where IPV is fitting in to the firearm research agenda and what attention is being paid to that specifically.

Dr. Mercy said that he skipped over many of the important research studies that NCIPC funded back in these days simply because he did not have time to present all of it. One of the areas for which there is strong policy evidence is on restraining order laws that restrain domestic batterers from possessing a firearm if they have been accused of battering. These laws have consistently been shown to reduce IPV homicides. This stems from the very work Dr. Frye cited and there are other areas where progress has been made, for example, in understanding unintentional injuries and suicide their relationship to safe storage and.

Dr. Wright highlighted an award in the new funding portfolio from the University of Michigan at Ann Arbor by Dr. Huesmann who is analyzing two longitudinal datasets to examine how individual, family, and neighborhood risk factors for gun violence affect the development of violence- and weapons-related social cognitions and behaviors into early adulthood.

Dr. Frye pointed out that a lot of the movement Dr. Mercy described came from taking a Critical Theory approach to examining differences in violence by men and women as victims and taking a critical feminist approach. She expressed hope that this will continue to be applied.

Dr. Chou observed that with COVID-19 and reports and some data suggesting an increase in suicide and/or violence and/or opioid-related issues, the mechanisms for funding this research are pretty slow. There is surveillance in place, but by the time some of this research is done, the pandemic may be over by a year or two. He wondered whether there are mechanisms in place to fast-track research, which could inform all sorts of policies related to lockdowns, schools closures, and all sorts of issues with which everyone is struggling. However, they are missing the opportunity to make an impact when it matters most if the research results do not come out for a year or two. This relates not only to firearms, but also all other topics. COVID-19 has made everyone rethink the traditional ways of funding and vetting research.

Dr. Mercy agreed that they need to find ways to speed up the research and recognized that the data often are not timely. For instance, the NVDRS is a year to a year and a half behind when things are happening in communities. States want to know what is occurring right now. He turned it back to the BSC to think about how they could advise NCIPC on how to do a better job of getting research out faster.

Dr. Wright indicated that they do have mechanisms for considering administrative supplements to support either COVID-19-related issues or other issues that recipients themselves bring to NCIPC's attention for which they are requesting assistance, or that program has determined to need further investigation. They are discussion this will all of NCIPC's divisions for all of the awards across the Injury Center.

Dr. Whitaker noted that there has been a tendency to think about violence in terms of targets such as IPV, youth violence, et cetera. Funding for gun violence introduces another way to "cut the deck." He was curious about whether NCIPC is considering targeting specific kinds of violence with the gun violence funding, or if they are thinking about diversifying it to assess some of the crosscutting issues.

Dr. Mercy said that they thought of it more in terms of diversification, particularly because this is NCIPC's first year of funding this. Perhaps as they go along, there may be targeted areas that will be more productive. In terms of the general approach they are taking, NCIPC understands that these different types of violence share many common risk and protective factors. However, all of their funding is siloed by specific type and oftentimes interventions are designed for specific types. He thinks they have to take more advantage of the crosscutting risk factors that these different types of violence share and focus on them. Many interventions are known to affect multiple types of violence. NCIPC's thinking more generally is to take better advantage of the crosscutting nature of or relationships among different types of violence rather than focusing on one specific type. However, each specific type of violence has some unique characteristics and circumstances that must be taken into account as well.

Regarding the suggestion to get research results out faster, **Dr. Coffin** pointed out that there are some mechanisms that he thinks are under-used at CDC and NIH. There are NOFOs that involved 2 mechanisms, one study and then a follow-up study tied to the success of the first study. While these have challenges, they overcome the barrier to getting solid research results with short timelines. As someone who lives on soft money, it is exhausting to do grants that are 1 or 2 years long. There is just not enough bandwidth to constantly be writing for the next award as soon as the first one is awarded, so longer time periods are needed. The promise of a 5-year timeline, even if it is 2 years and then a follow-up 3 years can be very helpful and draw in potentially higher quality research.

Dr. Mercy said that with that in mind, they did include 2-year awards in this funding. The point was to try to have a shorter period to get information out faster. Perhaps that is counterproductive and is one of the things they will need to better understand.

Dr. Kaplan said he is a big fan of the R21 mechanism. Suppose there is a mechanism that would allow the investigator to conduct exploratory developmental research in a shorter time, all the better. Regarding suggestions from the BSC, has been clear evidence over the past 12 months or so that gun background checks were beginning to spike based on the National Instant Criminal Background Check System (NICS). Monitoring the NICS program might be a helpful exercise for CDC.

Dr. Frye acknowledged that CDC is limited in funding research and nothing according to the Dickey Amendment promotes gun control. However, research does not necessarily promote gun control. She expressed interest in knowing why there was such a chilling effect on research and whether it was an internal unwillingness to fight the notion that research advocates for gun control. It is known that communities, and even the US democracy, is in serious danger from violent white supremacists, neo-Nazi, and neo-Fascist organizations that might include militias. There are some loosely connected groups and some well-organized groups, but they often are very well-armed. Some of these individuals and groups have a concentration of guns and they are often very well-trained, given that they have current or former military or police. It is clear now that this is real and can be quite effective and destructive. At same time and in response to this in part, there is growing popularity of gun ownership among groups of people who never would have thought of owning guns, but now actually feel that they might have to protect

themselves from those far right groups. There are even people who live in communities where there is a lot of community violence and they recognize guns as something that increases their family's risk, but they do not feel safe and they do not trust the police to keep them safe. There is an increase in openness to gun ownership in two groups where this generally has not occurred before, which is in direct response to far right neo-Fascist violence against communities of color and more broadly in other communities. She asked whether this was coming up at all in the NCIPC agenda for its research programs.

Dr. Mercy indicated that in answer to the first question, there was a concern that there could be repercussions for the Injury Center and CDC as a whole. This is what motivated the concern from CDC leadership. In response to the second question, there has been an increasing interested in countering extremism. He has not seen any concrete plans so far about addressing what just happened.

Dr. Maholmes indicated that NICHD/NIH also received funding as Dr. Mercy reported. The funded some of Dr. Campbell's work under this announcement. They are delighted to join with CDC in focusing on these priorities. Regarding the questions about how the work can continue, they have noted that it is necessary to build the field of researchers who are willing to do this work as well. Aside from some of the things Dr. Mercy mentioned, some researchers want to ensure that there is funding available if they are going to write these grants. There are issues pertaining to career trajectories for researchers. All of those things taken together may have impacted the field. It is a really complex issue beyond whether an agency leadership might make a decision to move forward or not.

Dr. Mercy added that NCIPC has been working closely with NIH and the National Institute of Justice (NIJ) in helping to coordinate the agencies' respective research around these issues.

From the primary care perspective, **Dr. Floyd** observed that primary care practitioners who are trying to work on this issue often feel beaten up and often abused by patients who they ask about gun ownership and gun safety. People have lashed out at him and his nurses about why they are asking these questions. He agrees that the research on risk is important, but he wondered how to get it into the hands of the policy-makers and those who are dealing with it at the grassroots level. Screening and other current efforts do not seem effective.

Dr. Mercy indicated that some of NCIPC's work addresses the work of primary care and hospitals on this issue, and he agreed that they need to do a better job in this area.

Dr. Maholmes emphasized that a focus on dissemination and implementation helps as well. When researchers publish the findings from their work, it helps to get the information into the hands of people who would benefit from the knowledge generated through the studies. Community-based participatory research (CBPR) and similar research that engages people in asking the critical questions ensures that shared interests are captured in the research and bringing people to the table. Many groups assemble advisory boards or steering committees so that people are talking together about the importance of the safety in their communities.

Dr. Wright shared that NCIPC has one funding recipient, Dr. Krista Mehari from the University of South Alabama, who is employing a CBPR approach to evaluate risky gun-related behaviors and the acceptability of specific approaches to prevention for populations at greatest risk for homicide (African American boys and young men) and suicide (older White men).

CDC's Firearm Surveillance Through Emergency Rooms (FASTER)

May Chen, PhD, MSPH
Behavioral Scientist
Division of Violence Prevention
National Center for Injury Prevention and Control

Dr. Chen provided and overview and update on one of NCIPC's initiatives, which is on syndromic surveillance known as the Firearm Surveillance Through Emergency Rooms (FASTER) Initiative. Syndromic surveillance is a collaborative effort funded through a cooperative agreement between local and state health departments, CDC, and other partners. The flow of syndromic surveillance data is that first people seek treatment in medical facilities such as EDs and their de-identified data (e.g., chief complaint, diagnosis code, patient characteristics, location) are sent to a local or state health department. These data feed into the National Syndromic Surveillance Program (NSSP) through the BioSense Platform. Within 24 hours of a patient's visit, the data become available within the BioSense Platform. As of November 2020, more than 5000 healthcare facilities covering 47 states and the District of Columbia (DC) contributed to the BioSense platform daily. The BioSense Platform covers about 73% of the nation's ED visits.[16]

Syndromic surveillance has the potential to provide timely and actionable data at the state and local levels that communities can use for prevention. Rather than providing population-estimates of burden, syndromic data are particularly useful for detecting trends, clustering of visits, and changing patterns for a particular public health problem in near real-time. In fact, DVP's colleagues in overdose prevention have been implementing the Drug Overdose Surveillance and Epidemiology (DOSE) System through which they use syndromic data to monitor non-fatal overdoses.
. The DVP initiated a program in 2019 that is now being led by the Division of Injury Prevention (DIP) to monitor non-fatal suicide-related outcomes. The FASTER initiative will now extend this work to include non-fatal firearm injury.

NCIPC's DVP recently developed a suite of firearm injury definitions to query data for relevant ED visits. This work was done in collaboration with colleagues from the NSSP Community of Practice that is now led by the Council of State and Territorial Epidemiologists (CSTE) and Houston Health Department and New York City Department of Health and Mental Hygiene, who both had existing case definitions upon which they were able to build. In terms of the components of the overall firearm injury definition DVP is using, syndrome definitions typically consist of the specific discharge diagnosis codes of ICD-9-CM. ICD-10-CM, and Systematized Nomenclature of Medicine (SNOMED). The definition also includes keywords to query chief complaints including common misspellings and typographical errors, acronyms and abbreviations, clinical and lay terms, and negation terms to exclude certain words.

[16] https://www.cdc.gov/nssp/participation-coverage-map.html

The ICD-9-CM codes that are included in the overall firearm injury syndrome definition include the following:

- ❑ E922(.0-.3, .8-.9) Accident cause by firearm
- ❑ E955(.0-.4, .9) Suicide and self-inflicted injury by firearms
- ❑ E965(.0-.4) Assault by firearms
- ❑ E970 Injury due to legal intervention by firearms
- ❑ E979.4 Terrorism involving firearms
- ❑ E985(.0-.4) Injury by firearms, undetermined intent
- ❑ Excludes air guns or table guns

The definition also includes ICD-10-CM codes that reflect similar intent type for the following injury intents due to firearms, as well as codes for initial encounters only:

- ❑ Unintentional
- ❑ Intentional self-harm
- ❑ Assault
- ❑ Undetermined intent
- ❑ Legal intervention
- ❑ Terrorism

ICD-10-CM codes are excluded for the following:

- ❑ Gas, air, or spring-operated guns (such as air guns, BB guns, paintball guns)
- ❑ Rubber bullets
- ❑ Rifle pellets
- ❑ War operations
- ❑ Military operations

The SNOMED-CT codes that align with the ICD-9 and ICD-10 codes include the following:

41430008	Shotgun slug, device (physical object)
56768003	Gunshot wound (morphologic abnormality)
63409001	Struck by firearm discharge (event)
69861004	Firearm, device (physical object)
77301004	Shotgun shot , device (physical object)
86122002	Bullet, device (physical object)
111050005	Bullet fragment, device (physical object)
219257002	Injury due to legal intervention by firearm (disorder)
283545005	Gun shot wound (disorder)
218081007	Accident caused by firearm missile (event)
218086002	Accident caused by automatic shotgun (event)
218082000	Accident caused by handgun (event)
218087006	Accident caused by hunting rifle (event)
218088001	Accident caused by military firearms (event)
269796009	Shotgun accident (finding)
242869008	Assault by firearms (event)
219199009	Assault by handguns (event)
219200007	Assault by pistol (event)
219201006	Assault by revolver (event)
219204003	Assault by hunting rifle (event)
219205002	Assault by military firearm (event)
219203009	Assault by shotgun (event)
219198001	Assault by firearms and explosives (event)
219142001	Suicide or self-inflicted injury by firearms and explosives (navigational concept)
219143006	Suicide or self-inflicted injury by handgun (navigational concept)
219144000	Suicide or self-inflicted injury by shotgun (navigational concept)
219145004	Suicide or self-inflicted injury by hunting rifle (navigational concept)
219146003	Suicide or self-inflicted injury by military firearm (navigational concept)
287184008	Attempted suicide - firearms (event)
287193009	Suicide - firearms (event)

Using natural language processing (NLP) and machine learning (ML) approaches, a number of key terms were identified including common spellings and misspellings:

- ❑ GSW
- ❑ Gunshot, buckshot (and gun shot, gun shoot, gun shout)
- ❑ Firearm, handgun, pistol, revolver, rifle, shotgun

- ❑ Been shot, I was shot, I got shot
- ❑ (Hit, ricochet, or graze) and (Bullet)
- ❑ (Gun) and (Wound)

Negation terms and common spellings and misspellings to exclude ED visits related to the following:

❑ No gun ❑ Remove gun ❑ Heard or hearing gun ❑ Hit head or hit my head ❑ Kickback ❑ Water, pellet, BB, rubber, paint, nerf, air, spring, nail, staple, stun, laser or Taser Guns ❑ Pistol whip ❑ Bloodshot ❑ Scope	❑ Fake ❑ Allergy or injection shot ❑ Follow up ❑ Chronic ❑ Wound check, care, or infection ❑ Drainage ❑ History of GSW ❑ Ago, past, prior, previous, or old GSW ❑ Z51.89 (after care)

All of these terms together were integrated into an overall definition that was embedded in the NSSP platform beginning in 2019. To date, they have received positive feedback from local, state, and national syndromic surveillance users of this definition. In 2020, they developed 3 additional firearm injury definitions by intent that are currently in the process of being refined.

In 2020, CDC's DVP initiated its FASTER Initiative to support jurisdictions to increase the timeliness and comprehensiveness of firearm injury reporting by using syndromic surveillance data. FASTER has 2 major objectives, which are to: 1) increase the timeliness of aggregate reporting of ED visits for nonfatal firearm injuries; and 2) disseminate surveillance findings to key stakeholders working to prevent or respond to firearm injuries. Together, these efforts will serve as a pilot to demonstrate the feasibility of monitoring non-fatal firearm injuries using syndromic surveillance data. This fills a major gap in the field considering that current data are typically 2 years old by the time they are available for analysis.

Through a competitive cooperative agreement, CDC funded 10 health departments to do this work, including: District of Columbia, Florida, Georgia, New Mexico, North Carolina, Oregon, Utah, Virginia, Washington, and West Virginia. Each state will be funded for 3 years from December 2020 through August 2023.

Under Objective 1 of the NOFO, recipients are expected to: 1) share real-time and historical case-level syndromic surveillance data dating back to 2016, which will allow CDC to consolidate trend data and track total non-fatal firearm injuries using ED data; 2) help create, validate, and monitor the quality of indicator syndrome definitions; 3) verify state and county aggregate quarterly reports generated by CDC; and 4) share methodology and aggregated reports with CDC. Under Objective 2, recipients are expected to: 1) create a dissemination plan by August 2021; 2) build and strengthen relationships with key stakeholders; and 3) implement dissemination strategies.

In terms of the project timeline, CDC had a project kick-off in September 2020 with the 10 funded health departments and since then had convened ongoing monthly individual state calls to discuss project updates. In October 2020, the recipient granted CDC access to their state syndromic data. In January 2021, states submitted their first quarterly report that included de-identified aggregated data for firearm-related injury ED visits for July-September 2020. Over the course of Year 1 funding, states will submit 2 more quarterly reports in April 2021 and July 2021. In May 2021, the DVP will host recipients for a reverse site visit to discussion progress on the project and goals for Years 2 and 3. Throughout this entire period, recipients have been actively reviewing and monitoring the quality indicator syndrome definition and working on their dissemination plans that are due in August 2021.

As this is a surveillance system that is only recently being used to monitor firearm-related injuries, there are several important limitations to consider. First, this is a non-probability sample and therefore the results are not generalizable to facilities not participating in the NSSP. Second, healthcare facility participation in NSSP can vary across months, with additional facilities being onboarded over time. Third, data incompleteness and quality is an issue for information on patient demographics, including race and ethnicity because of how the data are collected and recorded. Finally, syndromic surveillance data are transmitted to NSSP in near real-time and not considered finalized datasets.

Despite these limitations, it is important to highlight the value of the syndromic surveillance brings to the portfolio for non-fatal firearm injuries. Over the years, a great deal has been learned from how NCIPC uses Enhanced State Opioid Overdose Surveillance (ESOOS), DOSE, and Overdose Data to Action (OD2A) for detecting trends in opioid overdose in EDs in near real-time. The work has demonstrated the broad national coverage provided by NSSP; the ability to identify changes in patterns at the local, state, and national levels; and its potential for more rapid than ever feedback that can be used to facilitate the evaluation of local or statewide prevention efforts. With FASTER, NCIPC seeks to replicate and expand some of those successes to non-fatal firearm injuries.

Discussion Points

Dr. Kaplan indicated that most of his work focuses on firearm suicides for which the case fatality rate is 95% or so,. He wondered what could be learned using the FASTER Initiative about non-fatal firearm-related suicide attempts.

Dr. Chen indicated that one of the activities they are working on now is to refine their firearm injury definition by intent. A definition is available in the NSSP platform for unintentional self-inflicted non-fatal methods, but it is still in the process of being further refined. With that, hopefully they can shed some light on what Dr. Kaplan mentioned.

Dr. Frye said this reminded her of the olden days in the 1990s when they manually went to EDs once a quarter and abstracted from the physical treated and released case files of all injuries due to any weapon. She wondered how this talks to surveillance systems, or any systems, that aggregate non-gun weapon-related injuries and whether they would consider expanding this to non-firearm weapon-related treated and released or non-hospitalized non-lethal injuries. While the focus is on guns, most treated and released intentional injuries are not with guns. For the reason that Dr. Kaplan just described, guns are very effective at hospitalizing or killing people. Therefore, she was trying to understand how this fits into the broader intentional injury approach.

Dr. Chen indicated that the strength of this dataset is the timeliness of the data in terms of the ability to have near real-time information and the fact that they are able to look at patterns and trends at the local level. This is how she views this as differing from other surveillance systems that look at injury. They do have some interest in projects to compare and provide additional context to the data that they are now collecting.

Dr. Simon added that with syndromic surveillance, NCIPC has other definitions such as self-directed violence, child abuse and so forth. The FASTER system is designed specifically to assess firearm-related injuries. There are definitely utilities in syndromic surveillance for other forms of violence regardless of the mechanism of injury, which NCIPC plans to continue to expand.

Dr. Liller asked whether there are any plans to expand the FASTER system. Many states and localities are not involved, so she wondered what the plans are for future expansion.

Dr. Chen responded that they would be excited to see this expanded to additional states in the future, but much depends upon Congress.

NCIPC COVID-19 Activities

Division of Violence Prevention

Andrés Villaveces, MD, PhD
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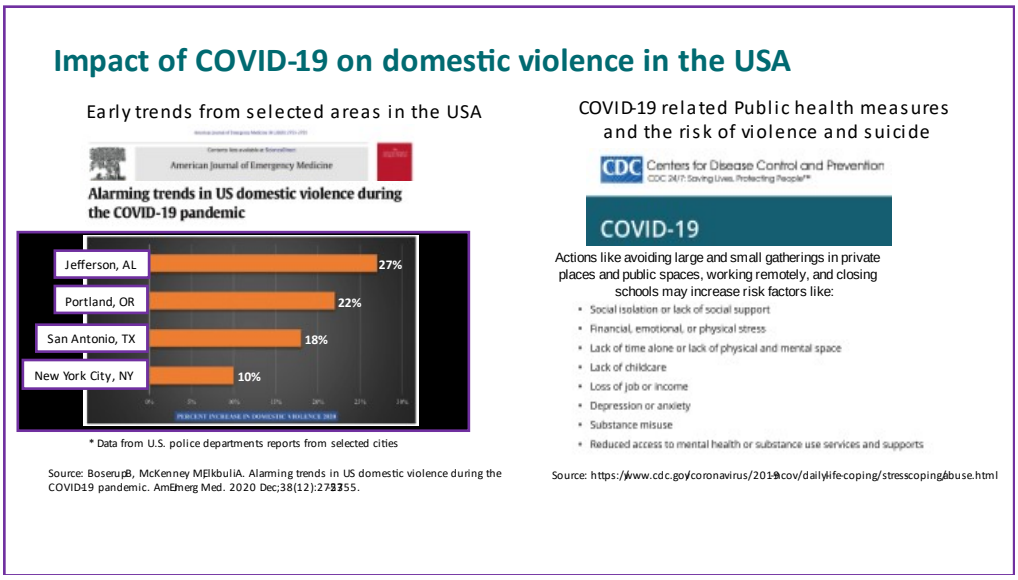
Dr. Villaveces reported on a project specifically addressing improving services for violence against children and women in the context of the COVID-19 pandemic. With the beginning of the pandemic, a series of media reports cited an urgent need emerging globally looking at hotlines in different countries that people were calling for problems with domestic violence. A majority of countries report substantial increases in those calls as the quarantine and lockdown were put in place.

The impact of COVID-19 on domestic violence in the USA also has been documented as depicted in the following reports:



On the left are a series of locations that reported those increases with different levels of magnitude. These data were collected through US police departments in selected cities. This is important because amongst all of the measures for mitigation and the public health-related measures that are recommended for COVID-19, the CDC also recognizes that a lot of those actions actually increase some of the risk factors associated with social isolation; financial, emotional, physical stressors; and competing demands such as childcare and or loss of job or income. These also have a lot of consequences in mental health, so there is a reason for examining and understanding this problem.

With this in mind and the evidence of the data that increased in those reports, NCIPC wanted to understand how services addressing domestic violence were coping, responding, and adapting during the pandemic. They conducted an assessment that focused on interviews with frontline providers and state leadership and reviewed these findings with a diverse group of stakeholders who work with these providers. The purpose was to generate a series of reports of the key findings, develop guidelines, and disseminate guidance/capacity-building for practice.

To do this, they engaged in a series of interviews with an aim to cover urban/rural areas, as large a geographic area as possible, and focus on special populations. Among the two groups of people who provide the services, 70 total interviews were conducted. Of the 70 interviews, 53 were with advocates of victims of domestic violence and violence against children from 25 states for the period from June through November 2020; 17 were with Child Protective Services (CPS) workers, and 15 were with Administrators from 10 states for the period December 2020 through January 2021. The information was captured through virtual qualitative interviews. The interview included 12 open-ended questions aimed at understanding how services are being provided, challenges and experiences with services, and the perceptions of the problem of violence in the current context. The analysis include identification of key findings using inductive thematic analysis and discussions with stakeholders.

The preliminary findings from the victim advocates reports showed that 49 respondents identified as female and they came from different ethnic, racial, and population backgrounds. The themes identified in the advocate interviews included the following:

- ❑ COVID-19 compounds the challenges of IPV survivors in relation to meeting basic needs. Issues such as shared housing and stress, access to cell phones/computers, and access to transportation were reported as problematic.

- ❑ COVID-19 is being used to control IPV survivors. Perpetrators do this by increasing isolation of victims, using financial abuse, or intentionally exposing victims to COVID-19 or limiting their access to protective equipment in order to keep them isolated in the home.

- ❑ COVID-19 mitigation strategies need to be balanced with trauma-informed practices. The increased isolation has been documented considerably more in LGBTI communities. There is the perception among a lot of victims that using a lot of protective equipment is like "going from one jail to another jail" due to the restrictions. It is perceived as a triggers for further restrictions and further control.

- ❑ Harm reduction and safety planning requires adaptation during the COVID-19 pandemic. There has been a lot of evidence from some communities of strength, creativity, and resilience. There have been discussions of avoiding risky places such as the bathroom or kitchen where a potential weapon might be present, making behavioral changes by victims such as not "rocking the boat" in order to avoid escalation, and reduced contact time with services.

- ❑ COVID-19 impacts survivor mental health, stress, and resilience. There is anxiety due to competing the competing risks of violence, COVID, and work. The use of social media is seen as an outlet among this population.

- ❑ Structural inequalities and discrimination have impacted marginalized IPV survivors during the COVID-19 pandemic. Racism and police brutality has affected minorities more. There has been xenophobia with immigrants through coercion with threats of deportation. There has been increased resilience at the community-level with some indigenous populations.

The preliminary findings for CPS frontline workers and administrators show that their threshold for eliciting investigations and reporting have remained the same. Agencies have continued to conduct regular visits and also use virtual options despite the fact that frontline workers and administrators are working from home. Field visits have been conducted outside the home or virtually when possible, and they highlighted that technical support has been key among these institutions. They documented an initial decrease in reporting, but there was an uptick when children returned to school. CPS workers have observed more severe cases. They have also noted significant stress from finances and childcare in addition to violence during this time. CPS and survivors have engaged more frequently on topics related to home-safety planning. Survivors have expressed concerns about children's safety, especially in shelters due to risk of COVID-19. CPS workers have highlighted the need to talk about support for parents even though that is beyond their mission. They also express that even with COVID-19 funds, the needs remain too high and the funds are still insufficient. CPS workers mentioned that services are siloed. For example, there is poor communication between CPS or survivor groups and healthcare personnel or providers.

The strengths of this research are that in-depth interviews were conducted to allow for an understanding of the context and links to services. Efforts were made to address the concerns of minority and special populations. This information will be used for capacity-building and guidance to professionals dealing with victims. There were some limitations in the respondent recruitment process. CPS was less responsive due to the protocols for responding and participating taking longer, resulting in less opportunity to talk with them. The interval to make decisions about responses can take months, there are possible differences between respondents and non-respondents, and not all areas of the US were covered. There also were limitations on the nature of the information in that it was not obtained directly from victims.

The next steps are to complete the analyses, publish manuscripts, begin the dissemination strategy, explore additional resources for healthcare providers, and strengthen connections between agencies addressing IPV and healthcare providers.

Division of Overdose Prevention

Nancy Worthington, PhD, MPH
Health Scientist
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National Center for Injury Prevention and Control

Dr. Worthington described one of DOP's COVID-19 activities, "Novel Harm Reduction and Treatment Strategies to Support Individuals with Opioid Use Disorder." Two main objectives drive this cooperative agreement between NCIPC and the National Council for Behavioral Health (NCBH), which are to: 1) identify and document novel, innovative, and emerging harm reduction strategies implemented as a result of the COVID-19 pandemic; and 2) fund promising strategies for ensuring or increasing access to services during COVID-19.

To underscore the urgency and importance of this work, Dr. Worthington spoke briefly about the impact of the COVID-19 pandemic on people who use drugs (PWUD) or have a substance use disorder (SUD). Preliminary research suggests that COVID-19 in the US may introduce new risks to the population, including increased morality. Not only can drug overdose put people at greater risk of contracting COVID-19 and experiencing more adverse illness outcomes, but also the pandemic can increase their risk of fatal overdose. Stress, anxiety, job loss, and social isolation can lead to increased substance use or return to use after remission, delays in seeking treatment or disruptions in access to treatment and naloxone, and people using substances alone without others around to administer naloxone or call for help in case of overdose.[17] This is demonstrated in terms of the percentage change in provisional drug overdose death counts from the 12 months ending in June 2019 to the 12 months ending in May 2020, during which most states reported increases ≥20%. Only 4 states reported percent decreases.

Access to harm reduction and treatment has become more critical than ever under these circumstances and though less apparent, harm reduction organizations have acted quickly and strategically to find new and innovative ways to continue service provision even as their own resources have dwindled or been stretched thin and even as other providers have reduced or shut down services. This project originated because NCIPC recognized that these novel harm reduction strategies could offer lessons for overdose prevention and substance use treatment more broadly and that funding support may be critical to promoting health and safety during this time. Finding support is critical for reducing COVID-19 among PWUD, while at the same time mitigating overdose risks and increasing engagement in harm reduction and treatment.

[17] Enns, A., et al. (2020). "Substance Use and Related Harms in the Context of COVID-19: A Conceptual Model." Health Promot Chronic Dis Prev Can 40(11-12): 342-349; Glick, S. N., et al. (2020). "The Impact of COVID-19 on Syringe Services Programs in the United States." AIDS Behav 24(9): 2466-2468; and Stack, E., et al. (2020). "The Impacts of COVID-19 on Mental Health, Substance Use, and Overdose Concerns of People Who Use Drugs in Rural Communities." J Addict Med.

There are 4 key activities that define this project:

1. An environmental scan of challenges and opportunities related to the provision of harm reduction services during COVID-19 that had two parts: a literature review of peer-reviewed, gray, and white literature between February 2020 and February 2021 and key informant interviews with field experts in leadership positions in harm reduction organizations.
2. The identification of effective and innovative harm reduction practices employed during COVID-19.
3. Funding harm reduction organizations to implement these practices and developing peer-to-peer learning opportunities among grantees.
4. The development of technical assistance (TA) tools to disseminate best and promising practices.

The project period began on August 1, 2020 and will end on July 31, 2021. To date, 21 key informant interviews have been conducted with field experts. The environmental scan report has been conducted and submitted and is undergoing revision. A competitive request for funding applications has been developed and released to over 100,000 stakeholders. Among the 233 applications received from 45 states and DC, 16 stakeholders have been selected for awards up to $33,333. An evaluation plan has been developed to assess program impacts and outcomes. While the environmental scan report is not yet finalized, the findings fall into 3 main categories, which are shown along with their subcategories in this table:

ENVIRONMENTAL SCAN: FINDINGS

I.	Impacts of the COVID-19 pandemic on **people who use drugs**	risk of contracting COVID-19; substance use related health harms; impact on mental health; social and economic harms; criminal legal system impacts; barriers to essential services
II.	Impacts of the COVID-19 pandemic on **harm Reduction organizations**	increased need for harm reduction services; operational disruptions; staffing; supply distributions; impact on workforce
III.	**Adaptations and innovations** made by harm reduction organizations	operational changes; technology-based adaptations and innovations; partnerships and collaborations; resources and tools

The 16 organizations selected for funding were from 15 states and DC and cover 9 HHS Regions and are listed in this table:

Organization	State
HIPS (Honoring Individual Power and Strength)	DC
The Perfectly Flawed Foundation	IL
Southside Harm Reduction Services	MN
Maine Access Points	ME
Milan Puskar Health Right	WV
Trystereo / New Orleans Harm Reduction Network	LA
Dave Purchase Project/Tacoma Needle Exchange	WA
Sex Workers and Allies Network of New Haven	CT
Iowa Harm Reduction Coalition	IA
Sonoran Prevention Works	AZ
NEXT Distro	NY (nationwide)
North Carolina Survivors Union	NC
Healthy Alaska Natives Foundation	AK
SWOP Behind Bars	FL
Bronx Movil	NY
SHOTS Tulsa	OK

Each organization will use the funds to implement one or more novel prevention strategy that enhance service provision during COVID-19. The following types of strategies were selected for funding:

- ❑ Distribution of harm reduction and hygiene supplies (no contact delivery; postal delivery; call in and secondary exchange)
- ❑ Communication and education (educational videos; online resource hub with chat function; virtual peer support meetings; Never Use Alone line)
- ❑ Outreach (mobile health unit; outreach van; outreach to homeless encampment)
- ❑ Low threshold employment for people who use drugs
- ❑ Linkage to care for individuals released from correctional facilities

The evaluation of the project will measure two main outcomes, which include: 1) improved capacity to identify, prioritize, and customize harm reduction programs and services to address public health needs during COVID-19; and 2) increased capability of public and behavioral health practitioners to implement evidence-based/informed harm reduction programs, policies, and services to address public health needs during COVID-19. There are two outputs that are expected to be in circulation soon. The first are the results from the environmental scan that are to be finalized for distribution in March 2021, and the second are TA tools to disseminate best and promising harm reduction practices during COVID-19.

Division of Injury Prevention

Ms. Danielle Arellano, MPH
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Division of Injury Prevention
National Center for Injury Prevention and Control

Ms. Arellano described information about a currently ongoing project within DIP, "COVID-19 project Prevention of Suicide, Intimate Partner Violence (IPV), and Adverse Childhood Experiences (ACEs) in Indian Country." She works closely with several partners as a Technical Monitor and also serves as the Lead Point of Contact for their team in the Program, Implementation, and Evaluation Branch (PIEB). The Injury Center dedicated resources to strengthen the Tribal public health response during the COVID-19 pandemic, with support of COVID-19 funding and the CDC Emergency Operations Center (EOC) to mitigate the elevated risk for violence in the home during an infectious disease outbreak like COVID-19.

This project seeks to address the higher burden of injuries and violence that are experienced in Indian Country, given that they are a group at higher risk. Pre-pandemic, American Indians and Alaska Natives (AI/AN) experienced a disproportionately higher rate of injury-related deaths. In comparing mortality by race, most recently in 2019, the overall injury rate for AI/AN was higher than other race groups and 1.6 the rate of non-Hispanic whites[18]. Fatal injury, homicide, and deaths by suicide are among the top leading causes of death for Native people 1 through 54 years of age and represent a significant number of deaths overall. Data from 2013-2018 show that deaths by suicide are the 8th leading cause of death for non-Hispanic AI/AN among all ages, and suicide is the 2nd leading cause of death among those 10 to 34 years of age[19]. IPV is common across the US and affects millions of people each year, but data show that Native people experience higher rates of IPV during their lifetimes. According to CDC's National Intimate Partner Violence and Sexual Violence Survey (NISVS), almost have (47.5%) of AI/AN women experience contact sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime compared to 37.3% of non-Hispanic white women. Among men, 40.5% of AI/AN men compared to 30.3% of non-Hispanic white men experience violence and/or stalking by an intimate partner[20]. AI/AN people are also more likely to experience ACEs. ACEs are potentially traumatic events that occur in childhood that are linked to chronic health problems, mental illness, and substance misuse in adulthood. Using data from the National Survey of Children's Health (NSCH), one analysis found the AI/AN children 0 to 17 years of age were more likely to have experienced 2 or more, 3 or more, and 4 or more ACEs compared to non-Hispanic white children[21]. A statewide health survey published in 2017 among American Indian adults in South Dakota showed that they displayed a higher prevalence of ACEs and had a higher total number of ACES compared with non-American Indians[22].

The Injury Center recognizes that extended home quarantine or isolation may have unintended effects on the potential for self-harm or violence in the home, increasing the risk for physical, emotional, and sexual violence against children, partners, and other family members such as elders. The purpose of the funding is to build Tribal public health capacity in the current COVID-19 response and its aftermath to prevent injuries and violence focusing on suicide, IPV, and ACEs that may be heightened in this time of COVID-19. This is a subproject of the CDC-RFA-OT18-1803 Tribal Public Health Capacity Building and Quality Improvement Cooperative Agreement through which $12 million has been distributed to 12 regional Indian Health Boards (IHBs) associated with Tribal Epidemiology Centers (TECs) for a 1-year funding duration that began in July 2020. This project provides opportunities for applied data-to-action approaches to improve Tribal data information systems and to use those data to support public health prevention efforts. There are 3 strategy areas of the project where approaches may be

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[18] CDC, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Feb 3, 2021

[19] Centers for Disease Control and Prevention, WISQARS: Fatal Injury Reports, 2013-2018. Accessed January 21, 2021

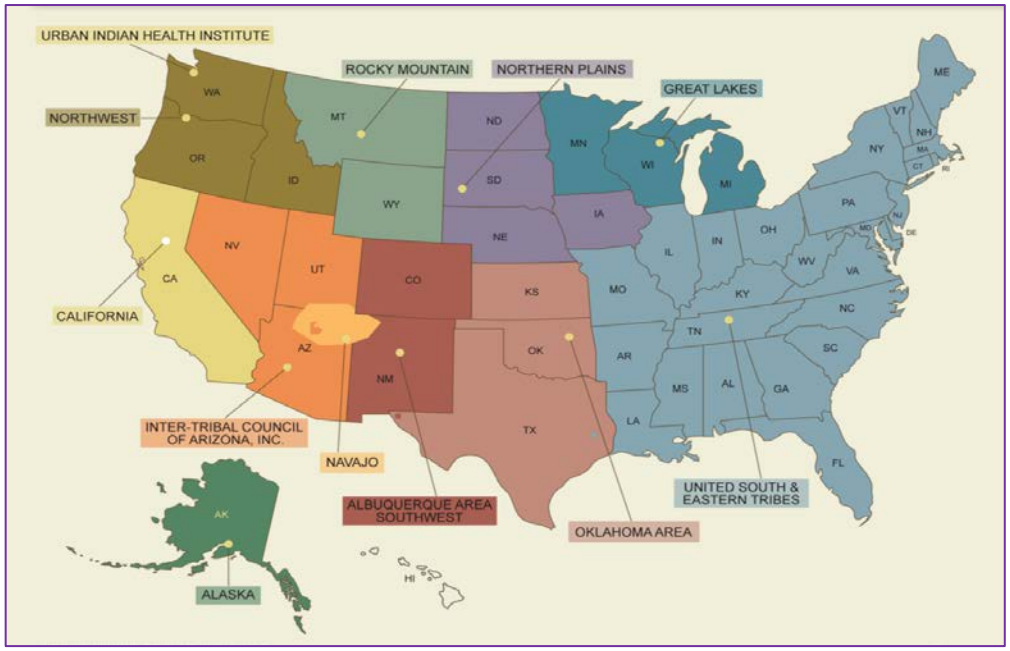
[20] Smith, S.G., Chen, J., Basile, K.C., Gilbert, L.K., Merrick, M.T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[21] Kenney MK, Singh GK. Adverse Childhood Experiences among American Indian/Alaska Native Children: The 2011-2012 National Survey of Children's Health. Scientifica (Cairo). 2016;2016:7424239.

[22] Warne, D, Dulacki K, Spurlock M, Meath T, Davise MM, Wright B, & McConnel KJ. Adverse Childhood Experiences (ACE) among American Indians in South Dakota and Associations with Mental Health Conditions, Alcohol Use, and Smoking. J Health Care Poor Underserved. 2017;28(4):1559-1577

implemented. The project was intended to be broad in scope and allow for adaptation as needed, utilizing CDC Technical Packages for each area of focus to highlight strategies based on the best available evidence, and serve as a resource to focus community efforts. Cultural adaptation and incorporation of traditional practices based on community input is encouraged and supported through this project. This funding also supports delivery of prevention efforts using telehealth and other distance means to accommodate physical distancing and measures recommended to prevent the spread of COVID-19.

This maps shows the locations of the 12 TECs and the regions that they serve, including the Urban American Indian population:



TECs were established starting in 1996 to address the lack of adequate public health surveillance and data for disease control in tribal populations. They are public health authorities who work in partnership with local or area Tribes to improve the health and wellbeing of their Tribal community members by offering culturally competent approaches that work toward eliminating health disparities that are faced by AI/AN populations.

NCIPC's partners are working in the 3 strategy areas of Tribal data and information systems, public health programs and services, and public health resources and communications to: 1) improve the collection, maintenance, and dissemination of Tribal health data; 2) translate evidence-based and evidence-informed practices into culturally appropriate public health programs, policies, and services; and 3) develop culturally relevant public health resources and communication tools. Partners have proposed activities in their work plans under each data-to-action approach addressing the 3 strategy areas. Rapid assessment are an aspect of each strategy. Assessments may quantify risk of suicide, ACEs, and IPV and quantify potential protective factors like positive childhood experiences, social connectedness, and traditional practices. Assessments may also identify and track relevant laws, policies, and programs and identify health communication needs to determine available resources and gaps. Some examples of activities in surveillance and evaluation include analyzing existing data and collecting new data to understand trends and identify at-risk groups in regional communities. In implementing prevention efforts, partners are reinforcing screening to identify and/or support follow-up resources, developing culturally appropriate communication toolkits, and adapting interventions for cultural relevance to support those at risk.

NCIPC's partners are actively working to make strides in their regions. Some accomplishments to date include 5 awardees who have provided sub-award funds to regional Tribes and Tribal health organizations in their service areas to assess needs and assets in communities to implement culturally adapted interventions. Another 5 recipients are finalizing sub-awards. Recipients also have conducted assessments particularly to understand the needs related to behavioral health services and communication tools in communities. For example, the Northwest Portland Area Indian Health Board (NPAIHB) conducted a health needs assessment with behavioral health providers. Partners also have developed risk communication tools and resources for their communities. For instance, the Albuquerque Area Indian Health Board (AAIHB) created factsheets to address the impact of COVID-19 on IPV and the Rocky Mountain Tribal Leaders Council (RMTLC) is developing an online resource mapping tool for Tribal communities to access. Partners have initiated collaborations with organizations to do this work, such as the Public Health Law Center and Johns Hopkins University (JHU) to assist with surveillance and communication activities. Several recipients are focusing on the intersection of IPV and missing and murdered indigenous women. The Great Plains Tribal Leaders Health Board (GPTCHB) and Great Lakes Inter-Tribal Council (GLITC) are working with task forces to assist with related data and surveillance activities. Additionally, the Urban Indian Health Institute (UIHI) is working with law enforcement agencies to improve data related to domestic violence cases during COVID-19.

Discussion Points

Dr. Coffin emphasized what great projects these are and stressed that such important work is often overlooked with the grassroots harm reduction providers. The supportive secondary exchange, mobile outreach, and so forth are critically needed at this time. He asked whether the work go into modalities being deployed by PWUD and whether there is still limited access to medication to treat OUD, notwithstanding telehealth, and whether there was a sign of a benefit from the improvement in telehealth that hypothetically would offer easier access to medications for OUD.

Dr. Worthington indicated that they did get some input into the modalities, particularly secondary exchange. As part of the evaluation, they are hoping to conduct interviews with participants of partnership programs on these strategies. A lot of the outreach work is done by volunteers who also are participating. One of the interesting things that came out of the telehealth was that a couple of programs adapted by providing pre-paid phones to individuals so that they could stay connected, and providers visited people directly so that they could access appointments that way. She is hoping that one of the TA tools to be disseminated will be on how to address some of the barriers to telehealth.

Dr. Cunningham expressed her appreciation for these presentations, emphasizing the importance of investing in the communities that are most affected by the overdose epidemic that has worsened. However, she was saddened to see the dollar amounts that went to the programs. Giving $33,000 to an organization is woefully inadequate and she believes they must invest more in the communities that are affected by this epidemic. She did not hear a lot about harm reduction organizations in terms of personal protective equipment (PPE) and the challenges that accompanied that. Harm reduction organizations may not be considered service providers and healthcare providers, yet they are the providers for a lot of patients with SUDs. Therefore, she wondered whether that issue was central in any of the organizations that were funded.

Dr. Worthington agreed that a lot more needs to be done about the funding amount. To reiterate, 233 applications were received. In terms of PPE, she heard this from the environmental scan as well. The organizations had serious difficulties in getting access to PPE, so in the distribution of the 5 organizations that asked for funding for that, will receive PPE.

With the spike in firearm ownership observed over the past 12 months or so and the increase in availability, **Dr. Kaplan** wondered whether there was any evidence of a rise in the incidence of firearm-related IPV or the related issue of homicides followed by suicides.

Dr. Villaveces said that from the data the DVP collected, there is not much information about firearm use. There is information about less lethal forms of violence, which increased, and the consequence that people have of increasing their tolerance to that abuse just to avoid escalation. While this is very important, it was not described clearly and distinctly by those whom they interviewed.

Dr. Dahlberg reminded everyone that Dr. Chen spoke about the firearm syndromic surveillance and the work that is being done at the state and local level. They have polled the national firearm syndromic data and are in the midst of analyzing those data right now. They do show an increase in firearm-related injuries treated in EDs, combined with some of the things that Dr. Mercy mentioned in terms of firearm violence increasing during COVID-19 as reported by various cities. Once they have all of these data put out, it will tell part of that story. The cannot tell the context of the injuries from the ED data in terms of whether they were IPV-related. If she had to guess based on the other surveillance data they see in EDs, the bulk of them are probably firearm-related assaults as a product of younger populations or youth communities. In terms of homicides followed by suicides that are fatal and do not present to the ED, she thinks they will be able to see some of those data in the NVDRS because it is incident-based. The problem is that they will not know that was the case until more than a year or two out from now.

Dr. Frye said she could not help but notice that there were data relevant to the presentation on overdose that was up-to-date and covered part of the COVID timeframe. However, some of the data that would speak to the incidence, prevalence, and changes in IPV and/or sexual violence over time was not presented. She would like to know what the plans are to look at those data across multiple surveillance and survey systems that CDC has. She also noted that the sexual violence data survey is incredibly old and wondered whether there is a plan for another nationally representative population-based survey on sexual violence. It does not seem like they got a sense of the change nationwide from the perspective of service providers. In response to Dr. Mercy's request for ideas, the subproject described by Ms. Arrellano sounded very promising and she wondered whether this could be offered to local and state health departments to do around the impact of COVID-19 on IPV and sexual violence at the city or state level.

Dr. Simon pointed out that NISVS is an ongoing surveillance system. NCIPC has been working with a contractor to improve the methodology for NISVS. There have been significant declines in the response rates from the random digit dialing (RDD) telephone surveys across systems. NISVS is no exception to that, so they are hoping to adapt some new methodologies and get back into the field with NISVS. They are currently working on a release from NISVS from the most recent data collected in 2016 and 2017, with a variety of papers in the pipeline. Regarding

the other data to assess patterns under COVID-19, a report was just released that was written by Arnold Ventures in collaboration with the National Commission on COVID-19 and Criminal Justice (CCJ)[23] that is pretty compelling and touches on some of the issues raised by Dr. Kaplan. While they did not look at homicide followed by suicide, but they did look at homicide rates in 34 American cities during the calendar year of 2020 and did a variety of comparisons. They also were able to look at intimate partner homicides as well. This report recently came out and documents pretty substantial increases. It also addresses non-fatal assaults in addition to homicide. Residential burglary decreased by 24%, but that is one of the few exceptions. Domestic violence increased during the early months of the pandemic, but the year-end rates were comparable to the year-end rates in 2019. He did not know if the resources would be available for Dr. Frye's suggestion to offer the subproject to local and state health departments, but they can look into this. Availability of resources and how they come to NICPC in terms of the flexibility they have to allocate those resources is limited.

Dr. Mercy added that he is not aware of any additional resources that are COVID-related that could be used for this. While this is an important point, it would require more funding.

Dr. Hedegaard commented that NCIPC and the National Center for Health Statistics (NCHS) have received many data requests over the last year and questions about the impact of COVID-19 on different kinds of injury-related deaths, particularly suicide and drug overdose. One of the limitations in trying to work with death data is that there is quite a lag between when the death occurs and when they get the data in the NVSS. For external cause types of death like suicide or drug overdose, it usually takes 6 to 9 months until enough data are in to allow for provisional estimates. During the time of COVID, that was not fast enough. The NCHS has done some statistical modeling using a methodology called nowcasting to try to estimate the final number based on what is known known at a given time. A paper will be published on February 26 that looks at the trends in drug overdose deaths, suicide, and transportation-related deaths through October 2020 during the early months of COVID. It is a technical paper that focuses primarily on the statistical methodology, but there are some estimates in terms of the patterns of suicide, drug overdose and transportation-related deaths during the first 10 months of COVID. She will be happy to send the BSC members the direct link once the paper is published

Dr. Chou asked about opioid overdose and the degree to which prescription opioid overdose can be distinguished from illicit opioid overdose. The actions and policy implications are likely to be quite different depending on that. The other piece that makes this information hard to interpret is that COVID-19 has major mental health impacts overall, so consideration has to be given to trying to distinguish whether overdose increases are related to lack of access versus increased mental health burden on people. The crux of the matter is that they can see these trends but must try to understand what to do about them. He wondered if surveillance would be able to get at the root causes of some of the data being seen.

Dr. Worthington agreed that this is an area that should be prioritized to try to tease out the pathways that are contributing.

Dr. Frye asked whether anyone has used big data or media analytics to look at detecting demonstrable increases.

Dr. Mercy indicated that one example is that they are exploring hotline data as a source for potentially looking at increases during this period, which they can get in a much timelier way. However, it has its own set of limitations. While he did not have an exact timeline, they are looking at this currently.

Dr. Liller emphasized that it is well-known in the injury community that in the AI/AN population there are enhanced injuries, violence, ACEs, substance abuse, et cetera. However, it seems as

[23] https://cdn.ymaws.com/councilonj.org/resource/resmgr/covid_commission/Year_End_Crime_Update_Design.pdf

if little is getting better after so many years. There are numerous interventions, but she wondered whether there were any efforts planned to look at sustainability of these interventions.

Dr. Qualters said that they are hoping to use the lessons learned from the work Ms. Arellano described and expand on them. As part of the suicide program, the Southern Plains Tribe in Oklahoma and the Wabanaki in Maine have been funded this year to build capacity for a multi-year program for suicide prevention. They are trying to learn from multiple pockets to see what works well in a population and what does not, and to use those lessons going forward.

Dr. Kaplan expressed concern about the continuing theme of data not being timely and wondered whether there is anything that can be done to speed this up. Fatal injuries are especially challenging in terms of getting timely mortality data.

Dr. Greenspan acknowledged that this is a concern at the agency and there is a public health modernization effort in effect. One of the primary goals is to have data be more efficient. Syndromic data can be acquired very quickly and there are efforts to look at social media. This effort is beginning to expand, and perhaps this would be a good presentation in the future. The NCHS is working on the effort to have data timelier and having provision data that can be produced in a shorter time span.

Dr. Hedegaard thought people from the Division of Vital Statistics would be happy to present during a BSC meeting. While the provisional data are not perfect, NCHS wants to make sure that whatever provisional data are released are reasonable. NCHS is getting closer to being able to present data 6 to 8 months after the death, which is actually pretty good considering all of the factors that go into investigating the death, reporting the death, and getting the data in a reasonable fashion to NCHS. She will work with Dr. Greenspan to discuss presenting to the BSC in the future.

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Public Comment

Richard Lawhern, PhD
Patient Advocate/Healthcare Writer
Alliance for the Treatment of Intractable Pain Name

I am Richard Lawhern, PhD. I am a patient advocate and healthcare writer with 25 years of experience in the field. Speaking on behalf of millions of pain patients whose lives have literally been destroyed by the 2016 CDC Guideline on Prescription of Opioid Analgesics. I am specifically concerned with the report of the BSC Opioid Working Group that was offered this morning, and I must apologize but I was unfortunately forced to step out during that, so this comment is in addition to whatever may have proceeded from that discussion. I understand that CDC intends to broaden the scope of its 2016 Guideline to address acute as well as chronic pain. It appears that the December 2020 Comparative Effectiveness Review Number 240 on Treatments for Acute Pain from Healthcare Research and Quality (AHRQ) may become a major input to these revisions. I must assert with some regret that COR 240 is a fatally flawed document for many of the same reasons as the 2016 Guidelines were. It reflects failures of scholarship, selective “cherry picking” of medical evidence to support a preordained political agenda, and grossly inappropriate methods of analysis. The Acting Director of AHRQ has refused to withdraw the report for an independent review team. Because of this, what I would regard as intransigence, I have filed a formal complaint on grounds of fraud and abuse with the Congressional Committee on Government Oversight and Reform. I can be available for discussion of related issues with Opioid Workgroup members at your convenience. Please include these remarks in your meeting minutes. Thank you for letting me speak.

Christine Moutier, MD
Chief Medical Officer
American Foundation for Suicide Prevention

My name is Dr. Christine Moutier. I serve as the Chief Medical Officer for the American Foundation for Suicide Prevention (AFSP). By way of introduction if you are not familiar, AFSP is our nation’s largest non-profit organization dedicated to saving lives and bringing hope to those affected by suicide. We have chapters and programs nationwide. I want to thank the BSC for giving me the opportunity to speak. AFSP is looking forward to continuing working with CDC and specifically wants to commend your comprehensive suicide prevention program as it expands to communities throughout the nation and targets vulnerable populations. We, as an organization, were founded as a research organization. However, now we are also providing suicide prevention education, support for loss survivors, and advocacy with active chapters in all 50 states. With that said, research remains at the core of our mission. As a leading private funder of suicide prevention research, we at AFSP rely heavily on data from the CDC. So, I encourage the continued work of expanding the implementation of the NVDRS, the National Violent Death Reporting System, and also expanding syndromic surveillance of suicide attempts and ideation data. By way of the prevention of firearm suicide, we at AFSP advocate for 4 main things: 1) the implementation of lethal means counseling in health professional settings; 2) working with the firearms-owning community, leadership, retailers, ranges, and instructors—work that we are now doing in 40 states in the US since the launch of the Project 2025; 3) supporting research regarding firearms and suicide prevention as was mentioned earlier in this meeting; and 4) supporting and evaluating extreme risk protection orders and the key components in that legislative policy function, as well as the areas we feel more research such as the impact of waiting periods. We welcome further conversations with all of you for how we may work together to effectively support each other’s suicide prevention efforts. We stand ready to continue working together. Thank you.

Cindy Herrick, BS, MA
Strategic Partnerships | Maternal Mental Health Awareness Week Lead
Maternal Suicide Awareness Campaign Lead

2020 Mom

I'm Cindy Herrick with an organization called 2020 Mom. We work to convene stakeholders across the nation to close gaps in maternal mental healthcare. Today I wanted to bring to your attention in terms of suicide prevention that maternal suicide is the leading cause of maternal mortality in many countries like the UK. In the US, we are currently working on getting maternal suicide rates. We know it's one of the leading causes of maternal mortality in the US. When you guys were talking about specific populations earlier, I just wanted to bring to your attention that this is something we have been working with and hopefully that you will consider as a population to look at. We do know that a lot of maternal suicides happen through violent means. We think that that is because it has to do with the mental state of a lot the moms and when they're in severe distress, they want to make sure that they complete the suicide. So, we feel that this is a very relevant area for you guys to consider.

Rose Bigham
Co-Chair
Washington Patients in Intractable Pain

Hi. I'm Rose Bigham with Washington Patients in Intractable Pain (WashPIP). I think a lot of people listening were hoping to get a more detailed update on the Opioid Prescribing Workgroup and we were startled to get just a couple of minutes. But, we are hopeful that there are going to be some good outcomes of that work coming soon. Today, we did hear quite a bit about efforts to help those struggling with either opioid use disorder or substance use disorder, harm reduction and outreach as we should. I think that's all great. What we did not hear were the efforts to assist current pain patients suffering from chronic high impact pain who are on long-term opioid therapy and getting their access to their medication during COVID or during this very challenging time. These are people with complex comorbidities who are overwhelmingly forced to risk COVID exposure in order to maintain continuity of care, seeing their providers, and going to the pharmacy because DEA does not let you deliver pain medications. When you talk about various marginalized groups, disabled people, specifically people with chronic high impact pain, should be one of those groups we are talking about and trying to ensure that they also get continuity of care during this crazy time we are in.

Olugbemiga "Olu" Ekundayo, MD, MPH, DrPH
Associate Professor
Northern Kentucky University

I am Olugbemiga Ekundayo from Northern Kentucky University. I just want to thank everybody on this board for the due diligence it pays to the people in the United States. I want to point out something that has come to my attention over about 17 years of experience reviewing proposals with the federal government. I am able to identify that there is some form of dissonance between policies and specific community priorities, and I will give an example. I just want to give an example, but I don't want to make it specific and direct. But what happened was that there were all these application responses to an RFP for tobacco control, and they were setting up all of these call centers all over the country. Some of the most prominent institutions in the country applied for all of these things, but it turned out that none of the applications addressed menthol in tobacco. But, at that time, 80% of the tobacco consumed in the Black population was menthol and none of them addressed it. There was some committee dissonance between the specific population needs and the policy. The policy was using an approach that was not addressing the needs of each of those populations. I am getting to the equity issue. I would like to appeal to the board to look at this one and see whether the way to truly engage the grantees and stakeholders and others is to really look at what are the needs of this population? How do you address it? Because when the person is in a specific population and they are writing, they will not necessarily write in a way . . . [time expired].

Terri Lewis, PhD, NCC
Clinical Educator

Practical Pain Management

Thank you very much for the opportunity to comment. I would like to take a moment to urge the members of this panel to please take seriously the issue of timely revision of the CDC Guideline for Chronic Pain. We have a catastrophe rolling out across the country in a wholly marginalized and invisible group. On top of that, we are losing workforce positions at a steady rate. Everybody is in the gun sights of policy that is not working for anybody. I beg you to please make this an urgent priority. Thank you for the opportunity to comment.

Becky Crippen
Nurse

My name is Becky. I have been a nurse for 21 years. I'm a mother, a friend, a wife. You know, all of the things that normal people are. My questions are about pain management. Since 2016, we have all been put through the wringer if you're a chronic pain patient or even acute pain patient for a broken bone, post-surgical, or just time doing damage to our body. So, what I would really like to know is where do you see pain management going say by the end of the year? Is the CDC trying to get rid of prescription pain relievers and can we call them that instead of drugs? Also, when we're making differentiation between overdose deaths, I know my state in Tennessee recently released this, but the differentiation between illicit drugs and prescription drugs for pain relievers like I said, because there's a staggering difference. Also, a lot of chronic pain patients are being forced to relieve their own pain, and by doing that they are turning to suicide. If these suicide rates have increased, I have a very, very strong feeling that this is at least part of the reason why. Also, we would love to know—I'm with a couple of organizations and we would love to know how to best navigate these waters to get us the medications we need to survive and have a quality of life. It feels like as the chronic pain community gets further and further away from medications to help their quality of life in addition to other treatment modalities, some people from the letter agencies are really happy just to let us die off.

Angie Goodgame
Founder
Pain Nation Foundation

First of all, I'd like to thank all of you for your service at the CDC. But as a former senior leader myself, unfortunately you don't understand what's going on in the weeds with chronic pain patients in particular, namely those that have intractable pain conditions, which means that they have pain 24/7. These patients are ill as a result of increasingly device-oriented surgical procedures that have injured these individuals and left them in pain. The doctor abandonment that was caused by your 2016 Guidelines that were written by physicians that are on this call that are involved with the physicians who are responsible for opiate prescribing have manipulated those guidelines with data that doesn't make any sense to those who aren't physicians. So as patients, we don't have true what we used to have in the United States, a true doctor/patient relationship because DEA is in the middle of our doctor/patient relationship as now are the guidelines that you all sent out similar to the guidelines that you sent out for COVID-19 to wear a mask, except those guidelines related to loss by insurance companies and were enforced by DEA to force doctors to treat our class of patients who are very ill and don't have a voice. No one will prescribe medication anymore. I'm forced to use the 90 milligram morphine equivalency that was written in your guidelines, and find out what science they used to determine 90 milligram morphine equivalency. We all have very strong suspicions that they all want us on suboxone, which is a medication which many of them who are on the task force for opioid prescribing guidelines are stakeholders in. I implore you to look at this. Again, thank you for your service.

Janice Garland
Disabled Nurse

I became and EMT in 1982, a paramedic in 1985, and am presently an RN that's disabled from a work-related injury in 2010. With that said, pain management has gone back to the 80s—literally. With that said, I implore you to look into the research that was used for the CDC Guideline. It was over 4000 reports that were low-grade medical evidence that was gathered by about an associate. That concerns me because there's a lot left out that could have benefitted people in pain. With that said, Andrew Kolodny and Jane Ballantyne were involved in the drafting of the guidelines. Both have recently admitted to conflicts of interest due to opioid litigations. There are several members through PROPS that are profiting off of opioid litigation. I find this highly unethical and disturbing on all levels in the science. This is not a science that I encountered in '92, '90 to '92 when I was in RN school. We have to get back to the science of this and from what I understand, 90 MME was an empirical number made up by Andrew Kolodny. Also, the Pain News Network tried to get the CDC guideline minutes and they released 1200 pages and 95% of it had been redacted to the point of uselessness. I submitted a request for those documents and plan to carry it my elected people within the coming days. I would appreciate some integrity put back in this process.

John Schoellman
Pain Patient

Hi. My name is John and I do appreciate what Angie and Becky said and I agree with them. In 2016, the CDC did create these guidelines and these were addiction specialists and they were not pain specialists. Now it caused a great horror for 50 million pain sufferers and 19.6 million pain sufferers that are high impacted. That's 4 or 5 years ago and nothing has been done to change the guidelines. No research money is spent on pain treatment. Out of all of the funds that they spent on OUD, nothing has been spent on pain research. AG William Barr said that they now realize that the drug overdoses were caused by illegal drugs coming across the border. *Newsweek* put an article out with their study saying that less than 1% get addicted that are taking the medication that are prescribed for pain. The reason why is because we are under scrutiny.

Mr. Victor Cabada reminded those who were unable to make comments or who would like to add additional comments to submit written comments to ncipcbsc@cdc.gov through February 23, 2021.

Written Comments

From:	Angie Millikin
To:	NCIPCBSC (CDC)
Subject:	Public comment re meeting 02 16 2021
Date:	Monday, February 22, 2021 2:09:42 PM

I implore the work group assigned to the CDC 2016 GLs on opioid prescribing to watch this Ted Talk from a reputable and very experienced Doctor at UAB Med school.

https://youtu.be/gMXHAPutGJA
Published on Nov 23, 2019
In this counterintuitive talk, physician Stefen Kertesz outlines how efforts to reduce the prescription of opioids has had a negative impact on patients who rely on the drugs to combat ongoing pain. Stefan Kertesz is a physician in internal and addiction medicine at the University of Alabama at Birmingham and Birmingham Veterans Affairs Medical Center. His clinical work and published research focuses on tailoring care for people with addiction and homelessness. Over the years, Dr. Kertesz has become a national voice on behalf of patients with long-term pain whose care has been impacted by institutional efforts to reduce opioid prescribing. Dr. Kertesz continues to advance research on improving primary care, addiction, pain and overdose risk in vulnerable populations, and serves on teams to support the Governor of Alabama's Opioid and Addiction Council. This talk was given at a TEDx event using the TED conference format but independently organized by a local community. Learn more at https://www.ted.com/tedx

Sincerely ,

Michelle Millikin , the sister of an intractable pain patient who was injured for life in a surgery in 2012

From: Carol Williams
To: NCIPCBSC (CDC)
Subject: Suffering unfairly
Date: Saturday, February 13, 2021 6:56:12 PM

To whom it may concern(hopefully everyone is concerned)

I writing do to the fact that the United States government has decided that people that suffer from chronic pain should not have the medication that gives them quality of life. These medications also help to give them a semblance of what their lives used to be like. Many of the people that have had the lose of their medication were only using it in a legal and responsible way. Once the lose occurs which most say is so they don't want people to become addicted and destroy their lives. What really seems to happen by taking the medication away their lives become unbearable plus unnecessary suffering that could be fixed with the return of their medication. It also takes the structure out of your live. It traps you in the house because of the pain so you have no productivity, you lose self worth and hurts financially because of loss of employment or having to pay people to do the things you use to. The real major financial problems come from trying to find a doctor or specialist that will help. The medical bills are huge and not something someone on social security or can't work are able to afford.Funny thing is taking medication from people that obtain medication and take it as prescribed are having their lives resemble that of addicts, this I not right to take away medication from patients that obtain prescription from trained doctors and take these medication as prescribed to treat their illnesses and injuries, just to protect people that aren't using it right or are using illegal drugs or illegal prescriptions. It seems you believe addicts and criminals deserve better life but then actual people who used legal medication for quality of life and for their right to life liberty and the pursuit of happiness.

I also ask you why call this an opioid epidemic because it kills 68,000 a year?
Then how about the alcohol epidemic it kills 88,000 a year?
Now for the real epidemic cigarettes and nicotine kills 490,000 a year and they have no medicinal value and are just as addictive. Let's not leave out that approximately 12,000 suicides are related to people battling chronic pain.

One last question is for as long as I can remember we were taught that marijuana was the gateway drug to heroin. Marijuana is a schedule 1 narcotic and prescription opioids are a schedule 2 but you have declared war on the people that make them,the doctors that treat with the medication and even the patients. Marijuana is a illegal drug and is being allowed to be grow and sold in storefronts and yet the federal government does nothing to stop open illegally sold marijuana but will not allow the use of legal medication that is controlling by doctors, government officials, pharmaceutical companies and ever the patients themselves. How and why is this the way disabled veterans, terminal cancer patients have to suffer? You are violating the human rights of Americans with disabilities by subjecting them to unnecessary suffering not just from pain but also emotionally, spiritually, mentally financially but worst of all can you image that you have been being treated with a medication that really made your life acceptable after a horrible medical problem and then after years of it giving the ability to continue on with your life acceptably only to lose it do to the crimes of others ? Even after that you still know that sitting in a pharmacy or hospital is that medication that gave you quality of life but there is nothing you can do to get it and you did nothing to cause the problem or to continue it?

Thank you and God Bless the good people that are suffering by no fault of their own but for the judgement of the political powers to be.

Brian Williams

From:	Debra Nolan
To:	NCIPCBSC (CDC)
Subject:	CDC Regulations on Opioid Medications
Date:	Sunday, February 21, 2021 10:04:05 AM

Dear CDC,
Please remove PROP and Andrew Kolondy from my healthcare. This group has never seen me. Never seen my MRI or CT scans. I understand they are confused. They need physiologic help. As the CDC stats prove the " opioid" problem is illegal fentynal, why are you allowing this group and the founder to destroy chronic pain patients lives? I get he needs to make millions from the conflicts of interest, but why is the CDC, a government agency meant to protect ALL citizens, allowing this? Andrew Kolondy has stated to a reporter that he is a " pain specialist". I can not find a medical license or proof of that anywhere in the professional licensing boards.
Patients in pain 24/7 deserve relief from pain. Injuries or debilitating diseases can affect anyone. You can die from a overdose of insulin. Yet has the CDC put a " one size fits all" approach to insulin? Does the DEA arrest doctors that prescribe insulin? If deaths are really a concern, is not alcohol a drug? There are way more deaths from alcohol, yet there is a liquor store on every corner.
I have had 13 stomach surgeries, 3 knee, a broke back and herniated discs on both lumbar and cervical spine. I did not ask for this to happen to me. No, the semi that hit me was not under the influence either. Yet it happened. I live in pain 24/7. My pain was managed before your 2016 " guidelines" and the frenzy of arresting medical professionals. Now due to fear of losing medical license and all the years doctors had to prove they are mentally and educated enough to provide care to patients, my medications were reduced. Thus landing me in bed 15-18 hours a day. I still hurt in bed. Never failed a drug test. Never failed a pill count. Why? Never got a " high" from my medications. Just relief from throbbing, unrelenting pain. IF I wanted a " high", it would be way less expensive to go illegal. Yet I have always obeyed the law and want my mental facilities to be present. I now have a new grand daughter. If my pain management doctor could treat me so I could be out of pain, I could enjoy her. I could make memories for her ,as I had with my grand mother. What is being done to pain patients is torture. Healthcare is not one size fits all. Yet only for CPP is it being done this way. Just so subloxone can be pushed. It is amazing that greed would destroy so many people's lives for money.
Please remember OUR rights. OUR lives are being destroyed for : 1. What we " may" do. 2. Convicted without trial or fault. 3. Discrimination for one area of healthcare. 4. Andrew Kolondy a PAID witness against pharmaceutical companies.
How can you allow this?? I am enclosing a pic of my grand daughter and her smiling at her Mimi (me). Your draconian rules regarding CPP are taking away her time and cherished memories she will have with her grandmother. Very real human suffering is being caused and CP patients are not the only victims. Please return to HUMANITY!
Sincerely,
Debra Nolan
P.S. I apologize for " run on" sentences, but I was up since 2am because of pain. Under treated pain.

From: Dellapenna, Alan J
To: NCIPCBSC (CDC)
Subject: BSC Comment
Date: Wednesday, February 17, 2021 12:18:02 PM
Attachments: image002.png

This is a comment for the NCIPC Board of Scientific Counselor's public comment period.

I head the Injury and Violence Prevention Program for the North Carolina Division of Public Health.

North Carolina is the 10th most populous state and experience a large burden of injury. We see the research and science priorities of NCICP well aligned with the needs we see in the state to prevent and reduce the burden of injury and violence.

We were the first state to identify an increase in medically prescribed opioid deaths and had the first CDC Epi Aide to investigate the increase in opioid deaths in the early 2000's. We saw thousands of deaths and lives impacted by over prescribing of opioids.

The 2016 CDC opioid prescribing guidelines was a milestone event for North Carolina's efforts to control excessive medically prescribed opioids. In 2017, North Carolina enacted the STOP Act that included limits on prescribing opioids for acute pain, the 2016 CDC opioid prescribing guidelines was a key reference that helped frame the STOP Act. The STOP Act passed the North Carolina General Assembly with unanimous votes throughout its legislative journey to passage, the magnitude of the medically prescribed opioids contribution of the opioid epidemic and the clear, science-based recommendations of CDC drove the passage of the STOP Act. We have seen medically prescribed opioid rates for acute pain decline since the enactment of the STOP Act. We welcome and support an update the CDC opioid prescribing guidelines.

Translating the NCIPC science agenda into action at the state level is what our program does. We value the science agenda and work to implement it in our priorities at the state. We see our role is being the office that provide the epidemiologic surveillance on injury and violence, focuses efforts on evidence-based strategies as reflected by the NCIPC science agenda, and be the ones that "answer the phone" when an injury issues arises in the state.

The Core State Injury and Violence Prevention Program (SVIPP) is the foundation that has enabled North Carolina to have staff to answer the phone on the existing and emergent injury and violence issues in North Carolina. Injury and Violence Prevention isn't traditional public health programs in many state health departments, NCIPC's impact through Core SVIPP is foundational and impactful in translating NCIPC's science agenda into action. Our work on the opioid epidemic started with under Core SVIPP. North Carolina has made significant and impactful progress on addressing the opioid epidemic. Core SVIPP was the foundation for years of work on the opioid epidemic that was expanded under Prescription Drugs for States and Overdose Data to Action.

Our program is one of the 9 awardees of the new Comprehensive Suicide Prevention Program this year. Core SVIPP enabled us to develop a pubic health approach to suicide for years before CSP was established. CSP will enable us to implement evidence-based strategies to reduce the burden of

suicide with a wide network of partners developed under Core SVIPP. We would not have been able to be a successful applicant to CSP without the foundational work started under Core SVIPP.

This year we also were among the 10 awardees for the new FASTER award. Our ability to do this this work started with the Surveillance Quality Improvement component of Core SVIPP. Our state has a communicable-based syndromic surveillance system that wasn't developed to conduct Emergency Department surveillance of injury and violence. We developed the injury surveillance capacity of the ED surveillance system under Core SVIPP, expanded it under OD2A and are in an ideal position to quickly implement FASTER. Without Core SVIPP, North Carolina would not have had the experience and ability to successfully implement FASTER.

We see the science agenda of NCIPC critical to the work we do at the state level reduce the burden of injury and violence. The Core SVIPP program is critical enabling state programs to maintain an office to translate the science agenda and recommendations of NCIPC into action.

Alan Dellapenna, Jr.
Branch Head, Injury and Violence Prevention Branch
Chronic Disease and Injury Section
North Carolina Department of Health and Human Services

(Home) **919-373-0680** – **Best way to reach me** during COVID-19 Teleworking
(Cell) 919-454-6559
(Office) 919-707-5441 – goes to voice mail during COVID-19 Teleworking
(Fax) 919-870-4803 – checked weekly during COVID-19 Teleworking
alan.dellapenna@dhhs.nc.gov

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Mail Address:
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Raleigh, NC 27699-1915

Street Address:
5505 Six Forks Road
Raleigh, NC 27609-3809

February 22, 2021

Opioid Workgroup of the National Center for Injury Prevention and Control
Board of Scientific Counselors
Christina A. Porucznik, PhD, MSPH
Chinazo O. Cunningham, MD, MS
Frank Floyd, MD, FACP
Elizabeth Haberman, PhD, MPH
Opioid Workgroup Members

Re: NCIPC-BSC Opioid Workgroup meeting February 16, 2021

The Arachnoiditis Society for Awareness and Prevention, ASAP, represents those afflicted with one of the most painful spinal disorders known to the medical establishment, the many forms of Arachnoiditis. It has been compared to having excruciating, unending pain worse than cancer but without the release from death. Unfortunately, there is no cure. However, the overwhelming majority have found some reduction of pain with the use of opioid medications.

Countless pain patients suffering with the worst forms of Arachnoiditis have been severely, negatively affected by the decisions of the last Workgroup when formulating the CDC's 2016 Guidelines for Opioid Prescribing for Chronic Pain (Guidelines) in the forms of losing their pain physicians due to fear of prosecution for prescribing opioids, or losing their pain medications altogether for no other reason than the draconian misapplication of the Guidelines causing forced tapers and withdrawals, as well as many choosing suicide over the unbearable pain of their daily lives without the proper dose of pain medication.

ASAP stands together in full support with The National Pain Council in their most recent letter to the Opioid Workgroup of the National Center for Injury Prevention and Disease Control Board of Scientific Counselors stating their serious concerns regarding statements made during the meeting held on February 16th, 2021. We firmly believe that The National Pain Council has outlined four critical areas of concern that must be addressed by the Workgroup posthaste in order to prevent further public harm.

Like many in the public who have stakeholder interests in the outcome of the Workgroup's efforts, we too were strongly dismayed to learn of the lack in the total number of meetings held to date when considering the multiple millions of lives directly affected along with the well documented numbers of lives already harmed as we all await the critically needed revisions to the 2016 CDC Guidelines. Four meetings in total for the calendar year 2021 cannot possibly address the overwhelming need of the multiple tens of millions of chronic and intractable pain patients currently suffering throughout the country. We support the National Pain Council's request for monthly meetings and believe this more adequately reflects the urgency of suffering and harm already imposed and frequently reported on due to the misapplication of the 2016 Guidelines.

We also are in complete agreement with the National Pain Council's request that *"Public recognition and re-release of an updated Guideline reflecting current science and all relevant evidence must become an urgent priority for the Workgroup and the Centers for Disease Control"*.

In addition, according to the NIH, there are nearly 30 million Americans suffering from daily chronic pain with over 10 million suffering from high impact pain. Among them are many who suffer from Arachnoiditis. These are some of your most critical stakeholders. They deserve no less than the opportunity to review proposed changes to the Guidelines during the process and throughout the 2021 calendar year. Not after these changes have been nearly completed and brought before the governing board in 2022. This completely shuts out the voice of those most directly impacted who hold the largest stake in the revised changes to the Guidelines. These are the very people who have suffered with untreated and undertreated severe pain for five long years along with their physicians. They deserve no less than a voice in the process.

And lastly, we wholeheartedly agree that should technical or any other difficulties arise with future meetings where public stakeholders are present and summarily shut out of the process to be heard and engaged by each and every member of the Workgroup, additional meetings are scheduled immediately so that those from the public who had registered to speak be heard in totality.

Respectfully submitted,

Arachnoiditis Society for Awareness and Prevention
Donna Corley – Director
Denise Molohon – Co-Director
Terri Anderson – Co-Founder
Rhonda Posey – Patient Outreach
Nancy Kriskovich – Patient Advocate
Michell Freeman – Patient Advocate

From:	Natalie Tietjen
To:	NCIPCBSC (CDC)
Cc:	Christine Moutier
Subject:	Dr. Christine Moutier, AFSP, Public Comments
Date:	Thursday, February 18, 2021 5:29:25 PM
Attachments:	Board of Scientific Counselors NCIPC Christine Moutier_Comment for the Record.pdf

Hi NCIPC BSC,

Please find attached public comments for the record from the American Foundation for Suicide Prevention's Chief Medical Officer, Christine Moutier, MD.

Please let me know if you have any questions.

Best,
Natalie

Natalie M. Tietjen
Manager, Federal Policy
Pronouns: she/her/hers
American Foundation for Suicide Prevention
440 First Street NW | Suite 300 | Washington, D.C. 20001
T 202.449.3600, ext. 1107 **F** 202.449.3601
Facebook | *Instagram* | *Twitter*

If you are in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting TALK to 741741.

From: Elizabeth Baatz
To: NCIPCBSC (CDC)
Subject: Opioid Prescribing Guidelines
Date: Wednesday, February 17, 2021 11:38:24 AM

I am writing to plead with you to please revise or straight up discontinue these guidelines that have brought so much suffering to the disabled men and women of this country. Enough time has passed to see that this effort has had NO positive effect on our country. Overdose deaths are up considerably due to a failed effort to curb the Opioid Epidemic. By limiting effective opioid pain medications to people with painful diseases the only result has been the torture of the most helpless and fragile population in the United States.

Prescription opioids are not what is causing overdoses. Patients in pain should not be suffering to prevent a small population from the possibility of addiction. When there is already a medication that addresses opioid addiction.

Thank you.

- Elizabeth Holland

From: Julia Heath
To: NCIPCBSC (CDC)
Subject: NCIPC BSC Webinar Feb 16th
Date: Tuesday, February 23, 2021 1:02:10 AM

We, the community, are writing as a unified voice to discuss the abysmal manner in which our community of stakeholders (patients with chronic pain, our physicians and caretakers) was summarily overlooked and/ or dismissed at the meeting of the NCIPC - BSC Opioid Workgroup on February 16th's webinar. This is an urgent, life and death issue for millions in America who suffer inescapable daily pain. Although our issue was not the only one on the agenda for the webinar, giving it 5 minutes of time in an 8 hour-long seminar is an insult, and must not be repeated. Additionally, being denied the opportunity to comment due to "technical difficulties" and/ or poor instructions after stakeholders waited patiently through the entire webinar is yet another example of the total disconnect this work group appears to have with not only one of its primary objectives - to identify and correct harms caused by the implementation of the guidelines- but also with the millions of patients and other stakeholders whose lives it has drastically affected for the worse. The dragging timeline and lack of urgency demonstrates tone-deafness to the agonies that the guidelines have unleashed for years.

CDC GUIDELINES TIMELINE
2015 - Guidelines to be released the following year were criticized and labeled "dangerous" by the American Medical Association; immediate rewrite strongly suggested
2016 - Guidelines released despite criticism to its content by multiple medical and professional agencies
2019 - Clarification of guidelines "intent" released by the CDC (took 3 years to clarify, but extensive national damage already rendered to stakeholders)
2021 - revision in progress; still no meaningful action since the clarification
2022 - anticipated release of draft revision (7 years following original warning of dangers from AMA, approx 5 years of damage rendered nationwide)

This timeline proves that extensive, damaging outcomes were predictable. Therefore, we insist that this Opioids work group do the following:
Adjust their calendars and schedules to increase the amount of times they meet to discuss this crucial issue of harms reduction from quarterly to monthly;
Reschedule the public comments session (which was severely interrupted due to technical difficulties and the natural weather disasters in several states) with all members of the work group required to be in attendance, alert, and engaged
Practice transparency regarding the scientific evidence it's reviewing in order to bring the guidelines up from conformation bias, cherry-picked information to unbiased evidence of current scientific data;
Confirm that the latest evidence clearly shows that the guidelines and resulting courses of action of state and federal legislations has failed to control the ever-increasing overdose rate caused by dangerous, contaminated illicit drugs and not prescription pain medication;
Find the character and courage to admit their errors and rescind or greatly revise the current guidelines in a timely manner, as good science is furthered from discovering what does and does not work, then acting on it.

Conclusions
The cause of opioid dependence is multifactorial, rooted in complex interactions between social, psychological, biological, and genetic factors.42 Heightened demand for diverted and illicit drugs might arise from limiting the supply of prescription opioids under certain conditions.43 These unintended consequences may occur if the fundamental causes of demand for opioids are not addressed and if the ability to reverse overdose is expanded without increasing treatment of opioid overdose. We believe that policy goals should be shifted from easy solutions (eg, dose reduction) to more difficult fundamental ones, focusing on improving social conditions that create demand for opioids and other illicit drugs.2

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776301?utm_source=twitter&utm_medium=social_jamajno&utm_term=4486960904&utm_campaign=article_alert&linkId=111248780

From: K. Kirell
To: NCIPCBSC (CDC)
Subject: My life in pain
Date: Tuesday, February 16, 2021 9:32:41 PM

I am 40 years old and have been in pain more than half my life. The forced tapering of opiates and increased scrutiny on rxs has caused me great mental and physical anguish as I struggle to find a MD who can adequately treat me.

I don't want to be in pain and need opiates in order to function at any feasible level. I am on disability and at the mercy of Medicare. Please stop punishing me for a situation I can not control. No one is yanking my benzos for my seizures, just treating me like an addict because my body does not function as it was supposed to and necessitates opiates to tamp the pain down.

Sincerely,
Kristin Kirell
45 Deepdale Drive
Commack, NY 11725
516-234-3317
K.kirell@gmail.com

From: Kevin Wolf
To: NCIPCBSC (CDC)
Subject: Questions related to BSC/NCIPC meeting on 2/16/2021
Date: Tuesday, February 16, 2021 12:13:25 PM

Hello,

Thanks for the topics covered. My questions are:

1. **Related to suicide prevention discussion**: For those terminally ill, they might want to have control over their death to avoid persistent pain or inevitable and unstoppable deterioration, is medically assisted suicide part of the discussion?

2. **On diversity equity discussion**: How is the shortfall in diversity recruiting into prevention and treatment healthcare studies being addressed? Has the diversity in such studies been increasing, decreasing or remaining the same and how measured?

3.

Please let me if you have any questions.

Thank you and take care,

Kevin Wolf, FSA, MAAA
Kevin Wolf & Associates, LLC
3047 N Lincoln Ave, Suite 400
Chicago IL. 60657

773-575-2128 voice
773-404-5837 fax

kevin.wolf.associates@gmail.com

From: Leslie Bythewood
To: NCIPCBSC (CDC)
Subject: Revising the CDC opioid guidelines
Date: Tuesday, February 16, 2021 12:17:38 PM

Here's a comment I'm forwarding from Dr. Thomas Kline:

"The CDC has no congressional authority to be making any suggestions or recommendations concerning the treatment of pain; all suggestions or recommendations must be cleared by the FDA."

Dr. Kline can be reached by email at: thomasklinemd@gmail.com

Thank you,
Leslie Bythewood

From: Lauren Deluca
To: NCIPCBSC (CDC)
Subject: CDC Opioid Task Force Meeting - Comments by CIAAG
Date: Wednesday, February 17, 2021 1:29:20 PM

Good Afternoon,

My name is Lauren Deluca and I am the Founding President of Chronic Illness Advocacy & Awareness Group, a national nonprofit organization representing the individuals who are negatively being impacted by the opioid sparing policies being promoted Federally.

Unfortunately, I was unable to speak at today's event due to technical difficulties. However, I would like to ensure to leave comment regarding the work being undertaken surrounding opioid medications at the CDC.

To date we have seen a small group of individuals have a controlling interest surrounding the topic of opioid medications. Many of these entities and individuals have been appointed to advisory positions on state and federal committees. However, rather than engage in productive dialogue that takes into account all stakeholders views and societal needs we have seen cherry-picking of studies to support personal and business agendas to the detriment of public health and safety.

As we move forward to address the dual crisis of addiction and untreated pain it is imperative we permit balanced representation at these committees. Those who have been appointed to represent individuals with chronic illness pain have egregiously failed to do so. Rather they have used their positions to promote their personal career aspirations and financial gain.

The individuals and organizations who represent themselves as "pain organizations" have abandoned their duty to the members they represent and have become a bureaucratic extension of the government, working to change the perception of pain in society, push for "self management" and "pain acceptance" over treatment and to work on the development the strategies and programs to accomplish said goals.

These individuals had a responsibility to review all evidence objectively and without bias to create a better system of pain care that reduced I the impacts of drug abuse on society and protecting rational medical supply of pain medications to serve the public wellbeing.

Instead these Organizations and individuals are working together to create mass marketing campaigns, with coordinated talking points with the goal to change the society perception of pain and ultimately it's treatment. There is a clear focus to create a narrative that opioid medications are ineffective when this blatantly untrue and only supported by fringe addiction groups who stand to benefit from the changes in healthcare policy.

When the members on our Federal committees are faced with public feedback that outlines the extensive harms done by the changes in the treatment of pain and access of medications they have been found to largely ignore it and proceed with their work unchanged. Even worse at times, we have seen these individuals cite patient feedback as a "sign of addiction" and that any evidence presented to advocate of behalf of the safe use of opioid medications are being presented as "reasons for the opioid crisis itself" Thus, effectively, gaslighting any and all advocacy efforts to protect those suffering with chronic illnesses and diseases with false

accusations and egregious misrepresentations of the facts.

This issue is deeply rooted into the handling of the opioid crisis and the pain studies being conducted/funded by NIH, as well as the prescribing guidelines being drawn up by several agencies including the CDC, AHRQ and the FDA.

In order to ensure balanced care we must first have balanced representation which includes those representing the issue of addiction, those promoting Alternative/Complementary care as well as individuals who promote palliative care rights and appropriate access to pharmaceutical medications.

We can come together to create a model of healthcare that serves the needs of all constituents by working collaboratively. However until the CDC, and other agencies permit full and equal participation from representatives for those in need of palliative care and pharmaceutical management of diseases, we will continue to see growing disparities and discrimination being codified into our healthcare system.

We are available for further discussion and commentary on this area and would welcome the opportunity to work with the members on the committee to help accomplish recommendations that serve all citizens while respecting their personal autonomy and civil rights.

Thank you,

Lauren Deluca
Founder
Chronic Illness Advocacy & Awareness Group, Inc.
Phone: 774-262-6671
Fax: 508-453-1033
www.ciaag.net

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Thank you,

Lauren Deluca
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From: LEONARD JENSEN
To: NCIPCBSC (CDC)
Subject: "Prescription Opiates"
Date: Monday, February 22, 2021 6:10:57 AM

Since the beginning of the Opiate crisis, most every CDC or FDA press release, pamphlet, and training content has placed the label of the crisis and drug overdose issue as caused by "Prescription" opiates. Nothing could be further from the truth.

This intentional slip of the tongue was intended to provide record funding to the CDC and its peer agencies record funding. And it worked!

Every member of the press and governmental and non-governmental organization and entity still labels the primary cause as Prescription Opiates. The real facts are that at least 90% of drug overdoses are caused by ILLEGAL Opiates such as heroin an fentanyl, imported from China and Mexico.

Chief personnel of the statistical branches of the FDA and even Canada estimates have tried and failed to correct this convenient error to no avail.

This tiny error has created a myth that intractable pain patients are the cause of the crisis and need to be labeled as crazed addicts and need to be controlled or forced into withdrawal and even suicide.

This tiny error has created a group of doctors and nurses that need no real excuse to punish patients. Most pain clinics in the U.S. have caused at least one suicide.

The CDC, FDA and all state Medical Boards agree there is NO authorization for litigation (suing) of medical professionals. They ALL fail to consider that all State Elder laws consider the intentional withholding of treatment from the elderly (60 years and over) a FELONY.

Federal law must therefore be altered to require prosecution of doctors and their nurses to be charged with a felony when they withhold opiates from an elderly intractable pain patient.

Or, would you rather use the usual excuse of Not My Problem and ignore the pain and suicides caused by current restrictions?

Leonard Jensen
1222 Thistle Hill Trail
Weatherford, Texas 76087
(817)944-1534
Leonard.jensen@att.net

Sent from my iPhone

From:	LES FISHER
To:	NCIPCBSC (CDC)
Cc:	david hemenway; Liller, Karen <kliller@health.usf.edu>, Amy Hunter <privateemail223798@connect.apha.org>, Kathleen F. Portland Carlson <kathleen.carlson@va.gov>, Dan Webster
Subject:	Re: comments on 2/16 meeting - suicides homicides violence ecologies
Date:	Tuesday, February 16, 2021 6:00:06 PM
Attachments:	NEJM 1976 or today IVP archetype.pdf Les Fisher written prress sample interviews NYT, TU,Rochester Democrat, etc 1970 1990 etc.pdf ajph1930GreatDepressionNegroSuicidesTotalAChanges (4).pdf Hemenway Building the injury field (1).pdf

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Historical examples of crosscutting ecological injury violence prevention research / practice related to cancer, et al research/practice:

https://www.nejm.org/doi/full/10.1056/NEJM197309062891003 (burn injuries served as a control for Hodgkin's combinability study in high schools)

file:///C:/Users/Leslie/Downloads/ajph1952brghtman.pdf (aged falls relationship to cancer)

https://www.nejm.org/doi/full/10.1056/NEJM197309062891003

Certain Children's Flame Retardant Pajamas: An Issue of Child Safety as Ecology, New York Times, April 30, 1974 (certain flame retardants associated with cancer). see also phosphate in water supplies.

file:///C:/Users/Leslie/Downloads/BurnsPJdetergents1974(1).pdf

> On Tuesday, February 16, 2021, 01:45:26 PM EST, LES FISHER <fisher166@verizon.net> wrote:
>
> Sent from Yahoo Mail on Android
>
> > ----- Forwarded Message -----
> > **From:** "LES FISHER" <fisher166@verizon.net>
> > **To:**
> > **Sent:** Tue, Feb 16, 2021 at 1:43 PM
> > **Subject:** Fw: comments on 2/16 meeting - suicides homicides violence ecologies
> >
> > Sent from Yahoo Mail on Android
> >
> > > ----- Forwarded Message -----
> > > **From:** "LES FISHER" <fisher166@verizon.net>
> > > **To:** "NCIPC BSC" <ncipcbsc@cdc.gov>
> > > **Sent:** Tue, Feb 16, 2021 at 1:01 PM
> > > **Subject:** comments on 2/16 meeting - suicides homicides violence ecologies
> > > Wm. Haddon, Jr. and his colleagues established modern injury and violence prevention (IVP) and mitigation . His "kinetics energies- gone wrong " -conceptualization focused on ecologic IVP causes; not just one vector, host or agent or environmental separated ecologically component.

We have substantially recognized his work; however, its application by some IVP specialist leaders has been diminished and less interagency/ disciplinary innovative collaboration has taken place .
Leadership in new real-world, historical in vivo, fluidity and ecology for IVP is now even more essential.

See my ebook- scroll down-
https://www.aphahistoryproject.org/category/membership-groups/history-of-sections/injury-control-and-emergency-health-service/

Les Fisher M P H

My views are my own and not necessarily those of any group nor organization

> On Tuesday, February 16, 2021, 08:57:19 AM EST, NCIPC BSC <no-reply@zoom.us> wrote:
>
> Hi Les Fisher,
>
> This is a reminder that "BSC Webinar" will begin in 1 hour on:
> Date Time: Feb 16, 2021 10:00 AM Eastern Time (US and Canada)
>
> Join from a PC, Mac, iPad, iPhone or Android device:
> Click Here to Join
> Note: This link should not be shared with others; it is unique to you.
> Passcode: 073651
> Add to Calendar Add to Google Calendar Add to Yahoo Calendar
>
> Or join by phone:
>
> US: +1 669 900 6833 or +1 929 205 6099 or +1 253 215 8782 or +1 301 715 8592 or +1 312 626 6799 or +1 346 248 7799
> Webinar ID: 852 1001 4152
> Passcode: 073651
> International numbers available:
> https://dceproductions.zoom.us/u/kcsSzfPUr0
>
> You can cancel your registration at any time.

NCIL
National Council
on Independent Living

www.ncil.org

Kelly Buckland
Executive Director

February 23, 2021

Re: NCIPC Board of Scientific Counselors February 16 Meeting

The National Council on Independent Living (NCIL) thanks you for the opportunity to provide public comment on the NCIPC Board of Scientific Counselors meeting, February 16, 2021. NCIL is the longest-running national cross-disability, grassroots organization run by and for people with disabilities. We represent thousands of individuals with disabilities and organizations including Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), and other organizations that advocate for the human and civil rights of people with disabilities throughout the country.

As an organization representing people with disabilities, many who live with chronic pain, NCIL works to protect the rights of people with chronic pain. Our work in this area began as efforts to address opioid addiction ramped up in the US, and we saw people with chronic pain left out of these efforts and harmed as a result.

We are pleased to hear the CDC Opioid Workgroup is revising the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. As part of this process, we hope that CDC staff will continue to interview people with disabilities and caregivers who have been affected by misapplication of the *Guideline*.

The NCIPC BSC meeting on February 16, 2021 left us with some concern regarding the timeline of the Opioid Workgroup and the revised *Guideline*. While the COVID-19 pandemic and severe weather emergencies obviously pose urgent challenges for CDC, they also exacerbate previously existing gaps in care for some of the most vulnerable patients.

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Washington, DC 20006
Email: ncil@ncil.org

We commend CDC on their April 2019 clarification warning against policies that misapply the *Guideline*.[1] However, since April 2019 we have not seen these misapplications corrected. Though the HHS Pain Management Best Practices Interagency Task Force cautions "the CDC Guideline was not intended to be model legislation,"[2] we continue to see state and federal legislation enacting numerical thresholds from the *Guideline* into law.[3]

The *Guideline* continues to be misapplied by insurance companies, state legislatures, Medicaid payers, state health departments, medical boards, pharmacy benefit managers, pharmacies, quality improvement organizations, and law enforcement. An issues paper published by the U.S. Food and Drug Administration (FDA) counts 526 new policies directed at opioid prescribing in 2016-2018 alone.[4] Contrary to CDC's safety warning,[5] policies that treat cautionary thresholds as hard limits remain in place.

Indeed, Senators Portman and Whitehouse are poised to reintroduce CARA 2.0 into this Congress – a bill with many laudable aspects but one which also features an inflexible 3 day limit for acute prescribing. In other words, it is just the sort of inflexible limit the CDC cautioned against and yet is being proposed as federal mandate.

In addition, we also continue to hear from members who are being forcibly tapered and left without access to healthcare altogether. We know of several individuals who were poised to provide comment during the last CDC meeting and who found themselves unable to. We have heard many voice frustration about the process who feel shut out from the public meetings.

Given continued harms from misapplication, revising the *Guideline* has become a matter of great urgency for the people NCIL represents. We reiterate our comment from June 2020, asking for explicit clarification that the *Guideline's* intended purpose is to

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[1] Letter from CDC Director Robert Redfield, April 10, 2019 https://static1.squarespace.com/static/54d50ceee4b05797b34869cf/t/5caf661d7f312b0001bac1b8/1554998814907/Alford+Final+.pdf; Dowell, D., Haegerich, T., Chou, R., *No Shortcuts to Safer Opioid Prescribing*, 380 New Eng. Jol of Med., 2285-2287 (2019) noting the danger to patient safety in misapplying the guideline, especially given the low evidentiary basis for the dosage and supply provisions. *See also* NCIL letter to Congress on Protecting Chronic Pain Patients and the CDC and FDA correctives, https://www.ncil.org/wp-content/uploads/2019/06/6-25-19-Chronic-Pain-Sign-On-Letter.pdf (This letter was signed by 100 of the top national and state disability rights groups.)

[2] Final Report, Pain Management Best Practices Inter-Agency Task Force: Updates, Gaps, Inconsistencies, and Recommendations, May 23, 2019, https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

[3] Portman, Whitehouse, Klobuchar Introduce CARA 2.0, December 10, 2020. https://www.portman.senate.gov/newsroom/press-releases/portman-whitehouse-klobuchar-introduce-cara-20-increase-access-treatment

[4] "Methods for Evaluating the Opioid Analgesic Risk Evaluation and Mitigation Strategy," Center for Drug Evaluation and Research, Food and Drug Administration, December 11, 2020. https://www.fda.gov/media/143549/download

[5] CDC Advises Against Misapplication of the *CDC Guideline for Prescribing Opioids for Chronic Pain,* April 24, 2019. https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html

guide primary care clinicians, not to set limits for broader systems charged with public health.

As of 2019, per capita opioid prescribing has fallen below 2002 levels. Projected 2020 data indicates another double-digit decrease, down to 2000 levels.[6] A revised *Guideline* could acknowledge how the regulatory environment has changed since 2016, and how patients have been affected by these changes.

Since June 2020, still more evidence has emerged showing patient harm from abrupt dosage reduction.[7] A revised *Guideline* could begin the process of reversing these harms.

Revisions to the *CDC Guideline* could also prevent new policies that incentivize dangerous tapering practices. As one example, Legal Action Center (LAC) has published recommendations for states to spend anticipated settlements from litigation against opioid manufacturers and distributors.[8] The report contains contradictory recommendations: while LAC does caution against mandates for abrupt dosage reduction, they also recommend quantity and dosage limits that would necessitate exactly that.

A revised *CDC Guideline* should warn against such contradictions before they solidify into policy. A revised *Guideline* could guide states to spend settlement dollars on lifesaving addiction treatment and access to medications for opioid use disorder, while clearly warning against prescribing limits that are known to result in harm.

A revised *Guideline* could also draw attention to limitations in the evidence base underlying the *Guideline*. In particular, the 2020 Agency for Healthcare Research and Quality evidence review "Opioid Treatments for Chronic Pain" acknowledges its own limitations: limited applicability to patients with severe pain, significant gaps in the evidence base, and inability to access individual patient data.[9]

Finally, a revised *Guideline* could restore lost access to care[10] by encouraging clinicians to accept new patients with long-term opioid prescriptions and by encouraging individualized risk/benefit assessment for each patient.

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[6] IQVIA Institute for Human Data Science, "Prescription Opioid Trends in the United States," December 2020. https://static1.squarespace.com/static/54d50ceee4b05797b34869cf/t/5fdd05e366149235d70ddfca/1608320487586/iqi-prescription-opioid-trends-in-the-us-1220-forweb.pdf

[7] Neprash, H.T., Gaye, M. & Barnett, M.L. Abrupt Discontinuation of Long-term Opioid Therapy Among Medicare Beneficiaries, 2012–2017. *J GEN INTERN MED* (2021). https://doi.org/10.1007/s11606-020-06402-z

[8] Legal Action Center, "Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic," October 2020. https://www.lac.org/assets/files/TheOpioidEbatement-v3.pdf

[9] Chou, Roger, et al. AHRQ Comparative Effectiveness Review "Opioids for Chronic Pain," https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioids-chronic-pain.pdf

[10] Lagisetty, Pooja et al. Assessing reasons for decreased primary care access for individuals on prescribed opioids, PAIN: November 11, 2020 - Volume Articles in Press - Issue - doi: 10.1097/j.pain.0000000000002145

The best available evidence remains consistent with patient comments to the CDC and with our anecdotal experience: while the majority of people with chronic pain do not benefit from opioid medication, a minority of individuals achieve sustained improvement in function and quality of life from opioid therapy.[11] Significantly, this includes people with disabilities who benefit from medication as part of comprehensive care for diverse medical conditions. CDC's public health responsibility has two urgent priorities: to prevent non-therapeutic prescribing, and to protect appropriate prescribing, which includes protecting this minority of individuals from harm.

We hope that CDC will expedite the work of the Opioid Workgroup, and we look forward to and very much hope for enhanced public participation in the development of the revised *Guideline*. Any questions or comments may be directed to Lindsay Baran, NCIL's Policy Analyst and Co-Chair of NCIL's Chronic Pain/ Opioids Task Force at lindsay@ncil.org.

[11] Darnall BD, et al. Patient-Centered Prescription Opioid Tapering in Community Outpatients With Chronic Pain. *JAMA Intern Med.* 2018;178(5):707–708. doi:10.1001/jamainternmed.2017.8709

From: chavezmarth@msn.com
To: NCIPCBSC (CDC)
Subject: 2016 CDC Guidelines
Date: Tuesday, February 16, 2021 6:06:34 PM

To Whom It May Concern:

I have been denied opioid medications for my condition of spinal stenosis. Kaiser no longer prescribes opioid pain relievers. Instead, after trying all the other alternative pain relievers they now offer and that do not relieve pain, they have abandoned me as a patient. After having a stomach bleeding incident because of taking too much ibuprofen, I now buy pain relievers illicitly. After trying all types of antidepressants, accupuncture, psychiatry, physical therapy and other junk science medicine for pain Kaiser now offers, they had me on 4000 mg of Tylenol and 1200 mg of ibuprofen daily and indefinitely. This is third world medical care and deadly to prescribe this long term. I need to work and I want to have some quality of life. Because of the misapplication of the 2016 CDC guidelines, I am at risk of overdose but the CDC and Kaiser policies have left me with no choice. The 2016 CDC guidelines are killing and torturing people everyday. This needs to change. Too many lives are being lost and ruined.

Sincerely,
M Chávez

Sent from my iPhone

From: carol limahelu
To: NCIPCBSC (CDC)
Subject: Meeting for 02/16/21
Date: Wednesday, February 10, 2021 8:36:40 AM

Comment:

The CDC 2016 Guideline has caused a ripple effect that has pushed doctors into retirement leaving patients abandoned with nowhere to turn.

The following is a list of actions the the CDC can take to mitigate the damage and hopefully save some lives:

1. The 2016 Guideline must be abolished. It is the most misunderstood misapplied health advice I have seen in the 68 years I have been alive.

2. Forced tapering must stop. The AMA has warned of its dangers.

3. The CDC needs to make it clear that physical dependence on a medication to live comfortably does NOT constitute addiction.

4. The multifaceted approach to pain management is nothing new. Most pain patients have gotten more than their share of psychotherapy and physical therapy and meditation and surgery.

5. The confidentiality of the doctor/patient relationship must be restored. HIPPA law does not apply to opioid prescribing, at least it is ignored.

6. No one should be made a hero by reporting a doctor. Pharmacists and insurance companies should not be practicing medicine.

We need all hands on deck to save the lives of people in pain.

Carol Limahelu

From: Noelle Pastor
To: NCIPCBSC (CDC)
Subject: Pain medication
Date: Tuesday, February 16, 2021 5:28:08 PM

I am 27 years old and I've lived with chronic pain since I was 16. I have an incurable, progressive genetic condition called Ehlers Danlos Syndrome. I suffered without pain medication until 2015 when my primary care dr started prescribing hydrocodone for pain. I got pain relief, was able to workout, go on runs and go to the gym, I was able to enjoy outings with friends and family, I was able to go on vacations, I was working full time and putting in overtime hours almost weekly, I was able to play with my nephews, I was fully participating in and enjoying my life. In 2018 I was cut off my pain medication and the reason given was "the CDC guidelines do not recommend opioids for chronic pain" I have since been denied pain medication 6 times, each time I was given the same reason, "the CDC guidelines do not recommend opioids for chronic pain"
I experienced no side effects from hydrocodone the entire time I was on it, only benefits which was noted by the physician who decided to take me off. The benefits were irrelevant to the dr and the only thing that mattered was "the cdc guidelines"
Since being taken off my pain medication I am no longer able to work to earn a living for myself, I had to apply for SSDI, and I am mainly bedbound/couch bound. I miss out on family vacations, I can't go outside and play with my nephews and new niece, I can't even play video games or board games with them because the pain is so intense and overwhelming. I no longer can go out with my friends, I'm unable to shower most days, I can't cook for myself anymore I'm no longer able to be physically active. I am constantly in pain every conscious moment.

I am mentally capable of making decisions regarding my body, my health and the medications I'm willing to take and that right has been taken away from me.
I have tried many non opioid medications and every available therapy in desperate attempt for pain relief, the only one that gave me pain relief and allowed me to function and enjoy life was the hydrocodone. It is my body and should ultimately be my choice what risks I'm willing to take. Pain patients are suffering immensely, some are committing suicide as it's the only way we have been left with to escape the unbearable pain. Recently I've seen some doctors stating chronic pain patients who were taken off their pain meds are suicidal because they are addicts and can't get their pills and that opioids cause suicide. I can assure you, neither of these assumptions are valid. These people are committing suicide because the pain is unbearable and we have been dismissed and no longer have any say in our treatment. Choices are being made for us by people who refuse to hear what we are saying.
Those of us who had been prescribed opioid pain medication and were benefiting from them, are now suffering because the CDC guidelines. The harm I am suffering now without pain medication is certain, the risks of taking pain medication are insignificant for people like myself. We benefit greatly from these medications. We deserve the right to make our own medical decisions.
It seems as though researchers are trying to find reasons not to utilize opioid pain medications, it's been a very biased approach since the CDC got involved and hasn't considered the thousands/millions who are safely benefiting from these medications.
The group the CDC picked to advise on the 2016 guidelines speaks for itself. Several of the selected individuals were paid medical experts who testify against opioid manufacturers. That in itself brought bias into the guidelines. The CDC opens these discussions to the public but doesn't even take into consideration what the thousands of us who are effected by this are saying.

If opioid pain medications helped even only a small portion of chronic pain patients, why would it be the goal to stop prescribing them? We are tired and exhausted and enduring unimaginable pain, we found something that is effective and that should be it we do not need to keep enduring these experiments. If a new medication is developed in the future that is effective for those of us who currently require opioid pain medication, great. Until then, stop allowing our effective pain medications to be taken away from us.

We are constantly being told “we need to find better options for treating chronic pain”
We already have a good and effective option for treating chronic pain, it’s just a method that has been turned into a political issue, made out to be much worse than it is in reality and blown up by the media and government.
Prescription opioid pain medication has been lumped together with illicit, unregulated, drugs. People are dying from illicit drugs because those contain harmful ingredients and people don’t know what they are consuming or how much. That is an entirely different issue than prescription opioids yet they are being handled in the same manner.
We have endured countless medication trials, injections, and therapies, taking away medication we finally found to be effective is unjustifiable and inhumane.

Unnecessary suffering needs to stop now. We don’t have time to keep waiting. The CDC decided to get involved and now it’s the CDCs responsibility to make it right for all chronic pain patients suffering as a direct result of the 2016 CDC guidelines. People are dying as a result of the 2016 guidelines and will continue to do so until our effective pain medications are restored.

Chronic pain patients absolutely benefit from opioid pain medication I can attest to that myself having first hand experience.
There is no other medical illness that is discriminated against the way chronic pain is.

I hope this time you listen to those of us who have the first hand experience and knowledge, those of us who are effected by the decisions you make.

Thank you for your time

From:	Peter Vaughn Pischke
To:	NCIPCBSC (CDC)
Subject:	Public Comment for the CDC February 16 meeting
Date:	Tuesday, February 16, 2021 5:16:58 PM

Hello CDC,

Peter Pischke, an independent reporter writing for several outlets including the Post Millennial,

I am a reporter on health and disability issues, as well as a disabled man of 13 years & strangely a sometimes-patient advocate.

When I spoke with you over a year ago, your panel made it clear you understood how perhaps millions of innocent, law-abiding pain patients, cancer patients, Veterans & many more are being abandoned & forced off the medicines that allow them to survive & live a semi-normal life.

Dr. Chou noted that even he had gotten in trouble for opioid prescribing, one of the architects' of 2016 guidelines had been attacked for taking care of patients?

You have all seen the studies that have come out in the last month, the opioid overdose crisis is worse than ever, at over 70,000 deaths a year (at minimum) yet prescription opioid prescribing is at a 20-year low, not seen since before the 1990s. But fentanyl deaths have increased over 1000% over the last 5 years. The hope in the hearts of the disabled & their families reflects the status of the dead.

To quote a recent article I did on the CDC's push to harm patients:

The CDC treats opioids as if they were just like smoking.

> But opioids *are not* tobacco. There is a genuine cost in tolls of human lives when you prohibit the essential component that makes the miracle of modern medicine possible. For 80 percent of the world's population, there is a desperate need for more opioids, *not less* iately, for American hospitals, the DEA, and politicians like Senator Elizabeth Warren, have idiotically encouraged an artificial shortage even while fig pandemic.
>
> I pray, dear readers, that when you hear that cancer kids are denied pain medication, that it makes you want to throw up. I can strongly remember watching my sister when she was only 3-years-old and fighting ovarian cancer. I cannot imagine the horrors inflicted by denying a child pain relief. Even for adults, being denied effective pain treatment can lead to significant health problems, including heart attacks and strokes.
>
> Yet, I have talked to hundreds of patients and families over the last four years, who have significant diseases such as cancer, and are still denied pain medication. It sounds insane, but every day, across the US, there is a scared medical professional who tells a patient in confidence: "sorry, I know you need this, but it isn't worth losing my license." Or "Sorry, I know your Dad is dying from pancreatic cancer, but I don't want him to become an addict."

There is no more room for excuses, you must heal the damage you caused.

We know 10 ways to Sunday; the opioid prohibition is killing innocent people. Lives stopped short by the uncaring negligence of the men and women meeting here today.

You know what you have enabled is wrong, & you know from the deepest parts of your souls that

you have erred greatly & must undo this wrong.

Your cowardice to meet your responsibility to patients is grossly negligent & ethically & morally barbaric

If you do not take this seriously & soon, History will remember you as monsters & it will have been fully deserved.

I ask you to please do what is right, screw the politics, didn't you become medical professionals & scientists because you wanted to help save lives.

US government agencies & international bodies like the WHO is advocating that children with cancer be denied access to pain medication. I've seen the horrors of cancer on our little ones, and your enabling of this practice should make you put your heads in shame.

Your efforts to stifle public comment today are gross.

Your actions have enabled the opposite, in light of the dozens of studies showing your gross error, I beg you to repent, overcome your biases & politics & let patients have access to their medications once again.

Please do what is right, screw the politics.

And may God & those whose lives have been lost judge mercifully on your souls.

- Peter Pischke

From:	Richard Lawhern
To:	NCIPCBSC (CDC)
Subject:	Follow-Up to February 16th BSC Meeting
Date:	Tuesday, February 16, 2021 5:37:42 PM

Thanks for allowing me to speak on today's meeting. The following is my effort to capture my presentation "as spoken". This should replace any previous text I have sent you for inclusion in meeting minutes.

Regards
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Public Comments to the Board of Scientific
Advisors CDC National Center for Injury Prevention
and Control February 16, 2021

Good afternoon. I am Richard A Lawhern, PhD, a patient advocate and healthcare writer with 25 years of experience in this field. I speak on behalf of millions of pain patients whose lives have been destroyed by the 2016 CDC Guidelines on prescription of opioid analgesics. Specifically, I am concerned with the report of the BSC Opioid Workgroup offered this morning. I regret that due to being called away, I missed hearing the presentation. Thus, these comments are offered as an addendum.

I understand that CDC intends to broaden the scope of its 2016 Guidelines to address acute as well as chronic pain treatment. The December 2020 “Comparative Outcomes Review 240” on treatments for acute pain from the US Agency for Healthcare Research and Quality may become a major input to such revisions.

I assert that COR-240 is a fatally flawed document, for many of the same reasons as the 2016 Guidelines. It reflects failures of scholarship, selective cherry-picking of medical evidence to support a preordained political agenda, and grossly inappropriate methods of analysis. The Acting Director of AHRQ has refused to withdraw the report for independent Review. Because of this intransigence, I have filed formal complaint on grounds of fraud and abuse, with the Congressional Committee on Government Oversight and Reform.

I can be available for discussion of related issues with the Opioid Workgroup members, at your convenience. Please include these remarks in your meeting minutes. Thank you for letting me speak.

==========
Richard A "Red" Lawhern
PhD Twitter: @Lawhern1
Facebook:
https://www.facebook.com/red.lawhern My
Publications: http://www.face-facts.org/Lawhern
Personal Website: http://www.lawhern.org

From: Stephen Doheney
To: NCIPCBSC (CDC)
Subject: 2016 Opioid Guidelines hurt
Date: Tuesday, February 16, 2021 6:05:45 PM

To whom it may concern,

My name is Stephen Doheney and I am writing to tell two stories; my own, and one that no longer has a voice. First, my best friend, Stephen Thomas Bowling. Stephen had a series compressed discs in his neck that could not be surgically rectified, fractures in his spine, and MS. He had been managed by his primary care doctor for a number of years. Stephen and I leaned on each other and gave each other strength. In 2016, Stephen was cut from his pain management without tapering. He was crassly told "If it really hurts that bad, I guess you'll have to kill yourself." by a staff member at his care facility. He followed that advice, while I tried to talk him down via phone. His pain didn't end there. His mother, father, brother, cousins, aunts and friends like myself will carry it the rest of our lives.

Seeing this fall out is motivation for me to endure in agony after I experienced a similar result in 2018. I had been on the same prescription for two years without increase while searching for more permanent pain management methods. My wonderful physician was forced to stop providing care after DEA pressure became too much for the practice and they could not longer keep up with thier regulations. They cut all thier pain management cases loose with no attempt to help them find supplemental care.

Now again, I find myself at the mercy of pain while I wait, for over a year now, for testicular Denervation surgery without any form of pain management. Physical exams result in physicians declaring I warrant and understand how to responsibility use pain medicine, but no one is willing to be the ones to provide them. Not for acute injury, not for chronic pain flares, not for dental work. It is an absolutely absurd act of cruelty to leave patients in unnecessary pain. We deserve access to medicine and procedures that grant the most improvement to quality of life with the least amount of side effects.

Thank you for taking the time to listen to patients and consider a different approach.

Sincerely,
Stephen Doheney

February 19, 2021

Opioid Workgroup of the National Center for Injury Prevention and Control
Board of Scientific Counselors
Christina A. Porucznik, PhD, MSPH
Chinazo O. Cunningham, MD, MS
Frank Floyd, MD, FACP
Elizabeth Haberman, PhD, MPH
Opioid Workgroup Members

Re: NCIPC-BSC Opioid Workgroup meeting February 16, 2021

We, the undersigned, are writing regarding the February 16, 2021 public meeting of the NCIPC-BSC Opioid Workgroup to request that members of the Workgroup acknowledge and take action regarding statements made during the meeting that we believe will create even further public harm.

1. Members of the public who have stakeholder interests in the outcome of this Workgroup's future recommendations were dismayed to learn that the Workgroup has only met twice. Although we understand public health officials have faced serious issues as a result of COVID-19, health care professionals, clinicians, and patients across the country are urgently awaiting a revision of the 2016 CDC Guideline for Opioid Prescribing for Chronic Pain, "the Guideline"{1}. The harms to patients from the Guideline have been well-documented {2}{3}, and a revision is urgently needed.

2. During the public meeting, the Workgroup announced their intention to meet once per quarter throughout the calendar year 2021. This is wholly inadequate, considering the burden of suffering the Guidelines have placed upon patients and clinicians over the last 5 years. Public recognition and re-release of an updated Guideline reflecting current science and all relevant evidence must become an urgent priority for the Workgroup and the Centers for Disease Control.

3. Next, the Workgroup suggested that the public would not have the opportunity to review the revised Guideline at any point during 2021, as they will be presented to a governing board first. This indicates that patients and clinicians will not have an opportunity to comment, critique, or influence the revision of the Guideline until sometime in 2022. This is an unacceptable time period for the millions of patients who suffer long-term, chronic, and high-impact pain. Millions of these patients, who benefit from long-term opioid therapy, have been immensely harmed by the misapplication of the Guideline and disruption of their care. This population is made up of 29.9 million American citizens who suffer from daily chronic pain and 10.6 million American citizens who suffer from High Impact Chronic Pain (HICP) according to the NIH.{4}

4. Last, we object to the manner in which the public comment period was conducted. Most attendees who waited patiently throughout the day-long meeting to give their comments were unable to do so due to technical difficulties and/or lack of instructions regarding the methods required to unmute and give comment. In addition, multiple members of the Workgroup appeared uninterested, unengaged, or absent from the public comment period.

Thus, we request, collectively, that the Workgroup take the following actions:

1. Restructure the schedule so the Workgroup meets monthly instead of quarterly to match the public health emergency of untreated/undertreated pain in the United States.

2. Practice transparency and provide regular updates to the public and health care professionals regarding both the scope and the evidence being reviewed for the revised Guideline. It is imperative that the NCIPC-BSC does not repeat the errors made during the creation of the 2016 Guideline, which was heavily criticized for its lack of transparency, lack of access during the public webinar introducing the Guideline, and other procedural and ethical issues.

3. Schedule an open public comment period no shorter than one (1) hour to allow all those who had registered or requested to give comments during the comment period subsequent to the meeting of February 16, 2021 the opportunity to do so, as is their right under Federal Guidelines.{5}

At such time, we the undersigned request that all members of the Workgroup are in attendance and actively participate, to allow all those who wish to comment, as time allows, to be adequately engaged and respectfully heard.

Sincerely,

[1]https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[2]https://www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/

[3]https://www.aafp.org/afp/2020/0415/p458.html

[4]https://www.nccih.nih.gov/research/research-results/prevalence-and-profile-of-high-impact-chronic-pain

[5]https://www.boundless.com/immigration-resources/how-to-submit-public-comment/#how-a-public-comment-works

Additional Organizations

Pain is Pain

CPP News Source - 4000 Members

Chronic Pain Voices, Administrator #1, Chronicpainvoices2016@gmail.com 5,000
Chronic Pain Voices Admin #2 , Chronicpainvoices2016@gmail.com
Chronic Pain Voices Admin #3 , Chronicpainvoices2016@gmail.com

Additional Signatories

87 in additional, for a total of exactly 1700 total responses (Individual + Orgs)

Lisa Eldridge
DK Cunningham, caretaker, adult child CPP (Chronic Pain Patient)
Ms Latha Steinbronn
Debbie skelly
Bjc
Sarah E Roberts
John Brandt
RTF
VerÃ³nica Kramer
Charles Campagna
Kristy Lynn Oliver
Angela C. Raye
C. Laux R.N.
Julie Bijou
Catherine
Christy Hartwein
LISA WRITT
Darlene King
Tami Jansen
Jessica Minerd-Massey
Cathy McGuire Kean
Pamela J. Sims
Carole Stedronsky
Jeff Driggers
Micki L Bradshaw
David E Schreiner
James Vanderwerf
Lysia Gilmore

Carolyn Kay Loomis
Carolyn Loomis Keith
Holland Kirsten Klang
Deborah Fimrite, Patient with high impact intractable pain
Sharon Reidy
Cindy Looney Cindy
Looney Audrey Liebl
Martha S Mozingo
Steven Shoger
Brenda Darwin
Tammy Malik Tiffany
Fields
Kim Manley Felix
Brizuela Megan
Stewart Heidi
Soens Mila A.
Johns
B.A. M.
Katherine Dominick Mr.
Jeffrey S. Edney Brian
Forman Shane Riddle
Kathy Adams, EdD
Malia Cole
Tammy Hintz
Michelle Kassorla, Ph.D.
Debra Emmel
David A. Donnelly
Cindy
Shane Sinclair Dena
Young Julianna
Weninger Jane
Shirley Rider-Pina
Andrea Darby
Janis L. Rivera, MA, CCC-SLP
HELEN HOFFMANN
Cindy Mullins (chronic intractable pain)
Randy N Beamer
William Heuck
Ms Willett
Kat Newman
Christina Jones
J. Thomas
Patricia A. Cody , Chronic Pain Patient
Travis Paulson
Kathy J. RN Jody
Ackerman V Kent
Bernice DeCiancio
Lisa RN
Julie Litten Bryan
L Odom Mrs. J.
Stewart Debbie

Tom Hayashi - caregiver, advocate
Mr Detwiler

Additional Comments

"First of all, my heart is bleeding for those who have lost a loved one due to an illegal drug overdose. As a mother, daughter, sister, friend, lover, partner or neighbor, I would also be looking for someone to pay for what I am experiencing right now, yet I will also be considering as people we must uphold self responsibility.

Has alcohol been prohibited? (Yeah, many years and guess what? It didnâ€™t work).

Are the insulin dosages regulated to a standard milligram per day? Is the blood pressure medicine regulated to a minimal mg per day? These medications can kill people if you under or over take them they are prescribed meds.

However we all know the CDC Opioid Guidelines from 2016 were premeditated and are a total fraud, no pain specialist or long term pain patient was in their panel these guidelines need to be abolished, deleted and disregarded immediately.

https://www.painnewsnetwork.org/stories/2020/4/15/what-is-cdc-trying-to-hide

I wonder what mathematical and science this group used to come up with the ridiculous idea of a maximum prescribing of 80 mg daily equivalent to Morphine, Why? What is the formula? According to whom? Based on which data? Actually it has been proven when dealing with intractable pain patients, the mere prescription of huge quantities of opioids doesnâ€™t mean anything, each person is unique, their body breaks down the medicine in so many different ways, one size does not fit all. Pain is the FIFTH vital sign although nowadays it has been totally left out from the list. That kind of controlled medication patients were managed on for over 20 years from battle wounds, work accidents, and back surgery failure, and never abuse or sell it for profit. Read the below link from Richard A â€œRedâ€ Lawhern, Ph.D, he has advocated for pain patients and their family members for over twenty years, with online research, physician referrals, authoring of websites and critical commentaries.Â Red is also the Director of Research for the Alliance for the Treatment of Intractable Pain (ATIP.)

http://face-facts.org/lawhern/

*** When the 2016 Opioid Guidelines were born in secret from the CDC director Freiden in cahoots with his friends:
- Andrew Kolondy (psychiatrist by school however a sociopath by choice) he is obstinately and intolerantly devoted to his own opinions and prejudices, he is the one who regards or treats the pain patients with hatred and intolerance (such and

achievement when he has NEVER actually treated a patient, not seen a patient on a one on one assessment)
https://www.acsh.org/news/2019/06/18/oh-klahoma-8-questions-jj-should-ask-andrew-kolodny-14100)
- Debra Houry (former Director of NCIPC)
https://www.acsh.org/news/2019/10/28/often-mistaken-never-doubt-dr-debra-houry-and-cdc-guidelines-opioid-prescription-chronic-pain-14363
- Jane Ballentyne (retired anesthesiologists who flip flops her opinion according to whatever she is being offered) from Physicians for Responsible Opioid Prescribing (PROP) and from Brandeis University in Waltham, MA, everything entangled and fell in line perfectly.
- The guidelines were immediately backed up so fast by the DEA, the DOJ and Stateâ€™s Medical Boards with full support from the Trump administration. It seems like a well thought out plan. Greed consumed a lot of politicians and naturally PROP is known to have big investments in addiction centers, medication and pharmaceuticals.
So many politicians turned their back on the disabled and pain sufferers

http://www.supportprop.org/board-of-directors/

https://www.painnewsnetwork.org/stories/2015/12/23/prop-and-the-opioid-lobby

My husband is disabled since 1999 and like many patients managed properly his prescribed meds over 20+ years for his severe intractable pain in the lower back due to a workplace accident, he has severe root nerve damage, called Adhesive Arachnoiditis we just canâ€™t comprehend how a medication is taken away from 29+ million Intractable Pain Patients and Wounded Veterans to stop addiction and overdose deaths when the whole government knows the overdose deaths are not rising since the 80â€™s. By 2012 is widely known nationwide the doctors are not prescribing pain meds, the pharmacist are refusing dispensing controlled meds, so why the ODâ€™s are still occurring, itâ€™s the drug cartels who are smuggling illicit drugs such as heroin and fentanyl, huge shipments from China have been confiscated repeatedly through 2020 at the USA Northeastern ports, last but not least is also the PATIENâ€™S own personal responsibility and doctor patient relationship.

Have any Senate Committees meet or interview chronic pain patients? Did anyone seating on those committees read or review the laws already established by the Social Security Administration, preventing wrong doing to the disabled patients, here is a refresh of the Social Security benefits please read again the following:

https://www.ssa.gov/OP_Home/ssact/title18/1801.htm

Also:

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE
Sec.Â 1801.Â [42 U.S.C. 1395]Â Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

On a final note, why clump together addicts with pain patientâ€™s? One is totally different from the other, the addict seeks the thrill of a high and kills emotional pain, while the pain patient seeks relief from their physical pain and is able to function in a somewhat normalcy.

VerÃ³nica Kramer
Pain Patient Advocate
jab_chaho@yahoo.com

Note:

Who supports PROP among other entities? The Steve Rummler HOPE Network which was founded in 2011 by Bill and Judy Rummler. Their son, Steve Rummler, died that year of an accidental opioid overdose after struggling with addiction brought on by efforts to manage his chronic pain, â€œso his family saysâ€, on the other hand Â they wonâ€™t tell that their son was already experiencing with illegal street drugs, instead they present it as if the doctor was the responsible for this to happen, you can read on their website."
Opioids can be the only thing that gives a person with chronic pain their life back or a slight glimmer of the life they once had and keep them going. It might make it so that they are able to work or care for themselves or their children. My mother can walk thanks to pain meds otherwise she would have to be in a nursing home most likely instead of at home with her husband of over 50 years. Not everyone is looking to get high or is going to have a problem, dependent, yes. But, that is because they are a necessity for them to live a life.
If you are unable to even listen to the community you are abusing, perhaps you will finally understand when you or someone you love experiences untreated pain destroying their life.

Believe us when we tell you, chronic pain patients taking their medication appropriately are NOT the people overdosing. We need to be heard!
I have untreated back n neck pain. No doctor wants me as a patient just because I have chronic back pain. Have been suffering for 14 years. I have had 3 surgeries, many injections, name it I've had it. Have been feeling suicidal lately. Please help us

I respectfully cosign all of this.
"Requiring pain management doctors to reduce or eliminate opioid treatment is inhumane. I suffered from severe pain caused by botched surgery 20 years ago. Dozens upon dozens of treatments, drugs, therapies, surgical and semi-surgical interventions were tried to NO effect. When I was finally about to end my own life rather than continue to attempt to exist with that never-ending, severe pain, teams of neurologists (and later, pain management doctors) finally agreed to opioid pain management. Once the dosage was raised to an effective level, far beyond what is now demanded by regulators, the pain was controlled. I was able to not only once again begin to live normally (not always trying to force myself asleep or just lying down unable to function). It was quite miraculous.

But after many years of successful opioid use, properly managed by pain doctors and without problem, regulators and local prosecutors demanded doctors reduce and eliminate opioid use, and my dosage was reduced as a result. Gradually, but enough so that the full elimination of pain is no longer possible. I can once again no longer do many things, like reading books or using my computer for more than a very few minutes. This response took two days to write.

I still get way over the demanded limits, enough to barely survive without screaming, but only in a limited way. Demandingâ€”and prosecutingâ€”doctors to reduce my dosage from afar is unconscionable and should not only be stopped, but reversed for people like me. Certainly, clean up ridiculous abuses, but leave careful, professional pain management doctors and their patients alone. Please. Have some humanity about this. If you've never experienced such a condition, you simply cannot understand how important this is. Opioids are not inherently evil. They can, and are, actually saving lives."

The damages the CDC has caused my family canâ€™t be computed to money because itâ€™s years off my life Iâ€™ll never get back to make memories with my family.

My meds have been tapered to a dose where I cannot get a sound sleep anymore. Not sleeping affects my pain, which affects my energy, and increases my anxiety and depression, which affects my pain.... It is a vicious circle.

Please make your revisions KNOWN to the doctors. Just as hard as you pounded the 2016 guidelines, you need to pound the revisions for CPPâ€™s. I deserve to be treated with dignity, no matter the medication needed. The government should not be involved in my personal health care.
Lack of PM is a violation of human rights. Withholding needed medical care to only one subset of the patient population is discrimination, and people are dying. Sounds a bit like genocide to me.

PLEASE..Treat chronic pain patients with compassion and allow them access to pain relief medications. Thanks!

"The time is now. Enough is enough. There have been so many needless deaths already, and there are many more to come, and they will continue; until some of those, in places of power, finally look at the proof & science and speak up! This has not only been affecting myself, my family and my friends- but yours as well. I can, almost, guarantee there is someone in your family hurting like this and you just don't know about it and you've been indoctrinated by the repeated, regurgitated, false narrative of the ""opioid crisis"".
There was like a 5-10 period when prescribing got a little overboard, but that was 15-20 years ago & we (the pain patient community, through their amazing advocates) have had enough time to compile proof upon proof that the 2016 CDC Guidelines have, without a doubt caused deaths, increased street drug use, mental health distress & many other traumatic harms upon not only patients (including veterans & injured workers) but their families, their caregivers and the compassionate medical community at large.
Let Us Live."
"When drug addicts use DRUGS their LIVES DECLINE, SPIRAL OUT OF CONTROL
When #Intractable Pain Patients use their TOOLS THEIR MEDICATIONS, FUNCTIONALITY AND QUALITY OF LIFE

Pain is Pain Facebook

IMPROVES DRAMATICALLY YOU CAN NOT COMPARE THE TWO"
Pain is relentless... Pain is cruel... It doesn't discriminate... It can happen to anyone! Everyone is just one car accident, surgery, illness away from living the rest of their lives in torturous, stabbing, aching, incessant intractable pain! Believe me this is a Journey you do not want. It is literally hell on earth!

You must stop punishing people with legitimate life long chronic pain. Being in pain 24/7 is punishing enough but your group doesn't want us to have any relief. You have gone too far.

You're KILLING us!!!

I fear by the time you read this, I will be another statistic. Who do we speak to to feel like we the disabled are being heard. What is there to gain by taking away a human medication that Has been on permanent total disability since 1989. Are your plans to rehabilitate me? I was born with defects of my femurs. Multiple surgeries over the years. Brain tumor not operable my choice. Please help.
I have a painful chronic illness, the pain is debilitating. I am losing tremendous amounts of weight since being cut off of pain meds because if I eat the pain is horrible, I now spend 24/7 in bed. No way to live.

This is urgent! We need transparency. I agree completely with this.
The CDC has injected itself wrongly into the relationship between patient and doctor, doctor and clinic, clinic and pharmacy. Doing this, the CDC is liable for the suffering of millions of Americans, plus the losses endured by their families.
I am disabled and wheelchair bound from Systemic Lupus, Transverse Myelitis, muscle weakness and intractable pain. I was abandoned by my latest PCP after 25 years of chronic pain and 16 years of opioid analgesic therapy at doses higher than the 2016 CDC recommendations. I was forced into a costly and dangerous detox. This past year I needed several major surgeries and was severely under medicated and suffered needlessly from acute pain during each recovery period because of arbitrary cutbacks in opiate prescribing. We absolutely need to restore our rights to effective treatment for pain with opiates when necessary.

Please change the Guide lines. Chronic pain patients are suffering
Help Chronic pain patients PLEASE!!!
Even my palliative care doctor is limited as to how much he can prescribe here in MA due to insurance. I almost wish I hadn't beaten stage IV metastatic breast cancer because this pain is too much for me to handle.

Eliminating the misrepresented CDC/PROP 2016 guidelines and revising a response for 2021 based on factual data is paramount to propagating the well being of all long term pain patients ability to live life to their fullest capability.

Please get the CDC off the pain patients back and give them their opioids. They are dying.!! They are killing my daughter and she will die this year. 2021 by decreasing her prescription without her permission. I will sue.

There are some of us suffering horribly. All we would like is to be treated like someone cares that there are some seriously ill people, such as myself, that need compassionate and understanding care..All the way around.. I would like to thank you for this as well..

We absolutely must address the fact that physicians clearly did not cause the opiate crisis. If anything, physicians kept it under check. Since the government took over, and physicians were moved aside there has been an exponential rise in addiction, sales of illicit Street opiates, and opiate related deaths. Based on my calculations, opioid related deaths have increased 24 since physicians lost power. There will always be some who fall through the cracks with us and charge, we are human. But the government is allowing everybody to fall through the cracks very legitimate patience with chronic pain needs who outnumber the number of addicts greater than 200 fold, are being allowed to suffer lose their jobs and commit suicide in droves. Gift physicians back their power and stop criminalizing legitimate, legal opiate distribution by physicians.
"The 2016 ""guidelines"" were deeply flawed and not developed under proper government procedure. The inclusion of PROP members who are highly biased and NOT Pain management doctors was extremely inappropriate. This same organization lobbied the FDA to change policies regarding Rx opioid pain medicines multiple times and was denied. They then created their own biased ""studies"" and cherry picked poor examples for their obviously biased narrative. The 50/90MME has no literature supporting it and even the AMA has said that needs to be abolished.
Patients with chronic pain have been severely harmed by the biased and flawed CDC ""guidelines"". They were created for primary care providers yet widely applied to all professions, even used by the DEA to threaten doctors that Chronic pain patients rely on. The CDC and the current work group are aware that the AMA, hundreds of doctors and other providers, and millions of patients have reported being harmed from the CDC ""guidelines"". It is imperative that the harm to patients be assessed and new appropriate guidelines be established that do not bar patients in pain access to necessary medications such as Rx opioids.
Your meetings are too few and far between to effectively help patients in pain who are suffering daily, whose numbers have seen increased suicides. Your last meeting with ""technical difficulties"" when patient advocates were speaking and lack of member effort to even listen to patient speakers or give them true consideration was shameful! People's lives are on the line! They are suffering and dying and yet you won't hear

them? You won't meet like this issue matters? Patients in pain deserve better! Do better! "

Please help ...Please do the right thing and let my doctor and myself decide what my daily dosage is..I just want a few pieces of my life back...No

As a husband to a chronic pain sufferer, this pretty much says it all.
I am the founder and owner of the group.
I have had chronic pancreatitis since 1999 as well as over 80 kidney stones in the past five years as well as a failed pancreas transplant surgery and need these medications the same as I require insulin
The guidelines have caused suffering and increased suicides. It has become an emergency situation. Please take action now!
By 2022 I will have completed the forced opioid taper I began summer 2020. My rare disorder does not have a treatment recommendation and, having already cut half my meds, I am now unable to eat due to the severity of my pain. After 15-years of full functionality as a mom, employee and wife, I am now anemic and Iâ€™ve lost 50lbs in 5 months. Please start taking my life seriously. I am a real person with a life to live, not a pawn in the war on opioids.

My son, a minor, has been severely impacted by the CDC 2016 Guidelines. He suffers constant and unyielding daily pain from Systemic Onset Juvenile Idiopathic Arthritis, and has been tapered, undertreated, and labeled with "Opioid Use Disorder" because of the misapplied 2016 CDC guidelines. No child should suffer as he does, constantly.

Pain patients need compassion not weaponized guidelines that prevent proper medical care
This opioid deprescribing nightmare has cost me my functionality and quality of life.

I would like to see people with painful diseases and injuries have their access to medications restored. Groups like PROP Only want to profit off putting everyone on Suboxone
It's appalling to think this is still going on against the chronically long term pain patient.
Transparency is key to moving forward for everyone all around!

"Time to stop penalizing chronic pain patients because you are trying to control substance abuse by true addicts. One of the real culprits is the fentanyl in illegal drugs from Mexico and other countries. One size does not fit all. You are interrupting the continuity of care for the patients who are suffering from real pain. What happened to ""First do no harm.."" (sic)?

In an effort to appear like you are attacking this problem aggressively to satisfy political pressures, you are disregarding millions of people who need access to these medications to control pain that prevents them from the activities of daily living. Imagine, yourselves, going into an ER, pharmacy, doctor's office and requesting help with such pain, only to be treated disrespectfully by those providers because you have attached such a stigma to a whole class of citizens seeking relief.

I have gone to the ER with my daughter who has suffered for 5-7 days with excruciating pain and been unable to care for her child with special needs; only to be told that they do not dispense narcotics for migraines. Please note that this is in spite of their requesting the medication(s) that ""work"" for her. When informed her neurologist agreed to a particular combination of drugs, they flat refuse. When asked why, they respond they are not willing to endanger their license by administering narcotics for pain if they believe the patient is drug-seeking. This is very disturbing!

One of her primary physicians ""fired"" her as a patient because the system showed she had been seen by numerous doctors in a short period of time for pain relief. The system didn't clarify that those had been ER visits, where one might see a different doctor each visit. I know because I had taken her.

Again, stop playing politics with people's lives and step up as physicians to care for all patients equally and not deny effective medication because you have judged them ""harmful"" to everyone you have painted with a broad brush."

I echo the sentiments and comments in this letter. I was interviewed by the CDC panel last year, and they stated that they understood the urgency for people like my wife, who has been abandoned by the medical community, and who has been bedridden for the past 2 years. Prior to that , on medication for over 20+ years with no incidents or complications, she was able to at least participate in life. You must listen to our stories, and act with conscience.

I wish I could have the same quality of life as my peers/ family. Instead I watch them and cannot join in. My pain is from lupus and I deserve to be able to enjoy my life.

Stop Punishing Chronic Pain Patients! I've taken my medication properly for well over 30 years and been force tapered. I probably don't even have much time left on this earth with my family as it is? I'll be 72 years old this March. So why must I be forced tapered? Left to be a burden to my loved ones by losing any remaining quality of life that I had been receiving prior to the 2016 CDC guidelines? Being left with next to nothing in the means of quality of life, which when I was given the proper opioid dosage I clearly was able to at least care for myself and do some daily activities. Used to be able to shop for myself, with the aid of a shopping cart of course and my medication. Now I'm left with hardly any functioning ability and often suffering in pain, barely able to do minimal daily activities without the assistance of my Family. Please please Stop Punishing those of us who believe in abiding by our laws!
Punishment of those in need of pain medicine to appease drug abusers is not the answer. Many people are living productive lives because they found a pain medicine and dose that gave them their lives back.
"Pain patients have been harmed by the CDC Guidelines. They have waited too many years already and need a revision that protects their rights to receive adequate pain management. They lost these rights in 2016. Patients are suffering when we have the knowledge and medication to provide them relief. Enough already. Too many have been lost waiting for these revisions.

I support this letter & its recommendations.

Thank you. "

"1 of 3

We represent roughly 5,000 Chronic Pain Patients CPP,Â Cancer Patients, Sickle Cell DIsease SCD & Veterans along with their caregivers & families. We list cancer & SCDÂ specifically because many falsely believe they are receiving appropriate pain control because of the GL ""exemption.""Â More don't understand when the exemption is applied correctly per the GL- it's ONLY for ""active cancer "" & for ""SCD in crisis.""Â Many cancer pts develop life long excruciating pain from surgeries & treatments ie chemo, yet many are denied just like any other CPP.Â Â Â

Same with SCD in crisis - they often have agonizing pain in between crises.Â They should receive pain meds as well. SCD Pts are often discriminated against beyond the

""normal CPP stigma"" ..... that we are all ""addicted"" or ""we're just one pill away from addiction."" None are backed by science nor the 20 million living high impact pain pts.Â But some ""addiction specialists"" ie Andrew Kolodny believes black people ``"are lucky "" """"stereotypes are protecting these patients from the addiction epidemic.""Â Sorry, we don't see refusing patients humane treatment as a ""good thing"" nor ""lucky."" . But then again, KolodnyÂ actually says it's better to take heroin than pain medication .He often shares his many biased beliefs on minorities & those diabled & suffering from uncontrolled agonizing pain. But at least he finally admitted to hisÂ conflict of interest - well after experts were calling him out on it.Â He not only helped develop the GL but he's been helping several states with their anti-prescribing laws and if there is an anti-opioid board of any kind- he makes sure he gets on it.

We have seen far too many caregivers/family members share videotapes of their loved one screaming in agony trying to get them pain relief.Â Some in Hospice but more in hospitals. A semi-counscious stage 4 bone cancer pt comes to mind.Â It took her weeks to pass.Â We can still hear her screams begging for help & for the pain to stop.Â Imagine what the family went through.Â Now imagine the torture that poor lady was forced to go through, only receiving Tylenol & Motrin because ""opioids could be addictive."" The poor woman had weeks to live! She begged her family to kill her to stop the pain & ""Hell"".Â Honestly don't know how they didn't go to the nearest street dealer & buy her pain medication. Statistically it's been proven many more forced tapered patients are going to the streets for illegal meds since the initiation of the GL.Â And sadly we may never know how many accidentally got the illegal counterfeit Fentanyl laced pills and overdosed.. CONTINUED 1 of 3"
"2 of 3
These events aren't isolated incidents by any means and some involve children who are even more heartbreaking listening to their begging. They are happening to all CPP no matter the cause of their pain.Â Excruciating is Excruciating- it shouldn't matter the reason- the point should be ""it's excruciating pain"" -Â PERIOD.Â

The CDC wrote letters back to these kinds ofÂ complaints/issues I mentioned above. They swore their GL was misapplied... not GL's fault! But whose fault is it then really? Where was/is your outrage CDC? Your GL are Torturing Legitimate Pain Patients & Children. Legit pts who haven't done anything wrong but become ill,Â injured or acquire a disease.Â Â Where were /are the press conferences imploring legislators to stop weaponizing your GL into laws?Â The Senate hearings?Â Reaching out to STOPÂ the suicides? Calling off The DEA from arresting good doctors who didn't do anything wrong (not the pill mill doctors - they deserve the arrest), The media outreach imploring doctors to administer compassionate individualized care & treatment to their patients- ""THAT'S NOT HOW THE GL WERE INTENDED!!!!"" Where is your outrage CDC??

We as advocates have listened as CPP have been forced tapered to zero or placed on such a low doses it barely registers as pain relief.Â We canâ€™t imagine getting 1/2 Percocet in the morning and the other 1/2 after dinner.Â Where is the humanity & compassion?Â We are talking very painful conditions are getting 1 -2Â Percocet a DAY in some cases and told by their Dr they don't want to lose their license, so they won't order more. And the worst part - they only order 20 total pills for the month. It's cruel & inhumane.
CONTINUED 2 OF 3
"
Arachnoiditis sufferer.
"3 OF 3
All these actions are supported or encouraged by the GL & /or it's workshops.Â While the CDC defends itself saying they are against forced tapering,Â it's the most common answer given to any question. If you function too well? Taper. Not functioning well enough? Taper.Â Â Pain too high whileÂ taking pain meds? Taper.Â Good pain reliefÂ achieved- Taper.Â Have common side effects of high long term pain - Taper.Â Common side effects of pain medication, uncontrolled- Taper. Common side effects, controlled - Taper.Â Â (This might be the reason so many have misapplied the GL.)

When exactly is it okay & supported to take medications, for a legacy CPP? Opioids are the most effective & safest medication for high impact pain , intractable pain, trauma, cancer etc. Â It's been used for thousands of years for a reason - it works & has few side effects to the majority of pain patients.Â Read the thousands upon thousands of letters & stories we keep writing and compare them to the latest statistics.Â Notice they match.Â Our country has an illegal/counterfeit drug problem.Â Prescriptions are at a 20yr low & overdoses are at a 20 year all time high.Â The GL are doing more harm to our nation than good.Â Â Canada followed our GL and stigmatized their own CPP , creating a patient care crisis there too.Â But Ontario revised their stating the same things we as patient advocates have been saying all along. They are unfounded-Â not supported by the data before, during or after they were written.Â Â There isn't good data supportingÂ 50 MME or 90 MME limits.Â Ontario as well as the AMA & HHS Pain Task Force says the same.Â We as a community are proof one size doesn't fit all. Many are nonfunctional at 50 MME others 120 MME.Â These limits must be removed in the revision.Â

AFTER 3 yrs of enduring terrible tortures, the CDCÂ published a couple of papers and sent several letters publicly stating it wasn't their intent to bring harmÂ (2019).Â The GL also created a Patient Care Crisis.Â Now we hear there's another delay occurring extending the wait - the revision won't happen until sometime in 2022 - 6 years of CPP

suffering & dying because they no longer can stand the constant & extreme levels of pain - and the CDC isÂ only going to meet every 3 mths ? We beg you to do better.Â

Thank you for taking the time to hear our voices.Â We support this open letter 100%Â andÂ agree with its recommendations.

"

"I 100% agree with this open letter & it's recommendations.

Pain Prescription prescribing is at an all time low yet overdoses from illegal street drugs & Illegally made counterfeit Fentanyl is at an all time high.Â More proof our country has an illegal drug problem yet they continue to punish legitimate pain patients.

The high majority of overdoses are by younger males,Â yet the highest majority of pain patients are older females. Â Furthermore ""some""Â complain seniors over 62 yo are still being prescribed pain medication at higher rates - like it's a bad thing. . YET seniors continue to be the lowest overdose population who have the highest amount of pain.

How does force tapering patients with the lowest overdose & addiction rates helping anyone? Answer - It's not and the latest statistics further proves this fact. Plus the suicide rates are climbing.Â Â Living the majority of one's day in excruciating pain is maddening.Â Â A high percentage of these patients will tell you once their severe excruciating levels are reduced to tolerable levels, their suicide ideations cease to exist. They're gone - poof.Â This is because suicidal thoughts are a means to stop the pain, not stop one's life. It's about the pain & we can not stress this fact enough.Â Forget the crazy idea ""it's withdrawal pain"" - for months & years? Not saying you can't have rebound withdrawal pain , I'm saying that they are two different situations. That person is spreading purposeful misinformation.Â But he spreads that a lot.Â I just read another statement in an article or Tweet by him (Andrew Kolodny) that said ""you're better off to start heroin than pain pills. ""Â

There are mothers & fathers who are now confined to a wheelchair,Â bed or even their home - unable to function with such high levels of pain. Not ""OIH Opioid Induced Hyperalgesia"" either, that's very rare. Real pain - the reason they had to take the meds to begin with. They are being tapered w/o their consent and w/o signs of abuse or addiction.Â

And who really suffers?Â Their children, their families - their community & themselves even more . These kids had working parents who were able to be active for many years while receiving adequate pain relief.Â Then through no fault of their own, the sky fell taking with it their functioning abilities and their Quality of Life QOL.Â It was due to the CDC Guidelines.

Homebound & bedridden patients have a terrible Quality of Life QOL with a decreased life expediency & increased comorbidities.Â Today with the pandemic that's a very bad thing.Â The DEA & previous administration severely cut back opioid manufacturing leaving COVID units short on these medications.Â That means patients on ventilators weren't receiving the proper care they needed. Some pain patients couldn't get their meds.Â I hate to think what will happen if another wave hits - because we don't have enough pain meds - IV or PO.

Ontario recently rescinded their 2017 Opioid Guidelines.Â Stating the same things pain patients , advocates & pain experts have been saying all along - ""Forced tapering is inappropriate."" ""We need individualized care "" ""No MME limits "" etc.Â Their data proved the same as our CDC - it's a illegal street drug problem.Â Â Tapers need to be voluntary and slow.Â If there is a problem (liked increased severe pain or terrible withdrawal symptoms) the taper needs stopped & reversed.Â Â These exact directions need added to the revision.

We need the guidelines severely revised to undue the harms that have been committed because of them.Â We cannot wait another year.Â So many things need changed- how can you do this only meeting every 3 months? This is not acceptable.Â Patients are dying,Â actually dying waiting on these to change.Â

We also need a longer comment period.Â Something went wrong on the Feb 16th meeting- there wasn't an ""unmute"" button.Â Those people waited & wanted to speak - the Workgroup needs to hear them... and really listen.

Thank you for your time. "

"In my 60 plus years, Iâ€™ve seen little that equals the cruelty, on a mass scale, that has been visited on chronic, intractable pain patients, by the indifference and inaction of those with the ability to do something. By the CDCâ€™s own reckoning, 1 in 10

suicides is related to chronic pain and Dr. Emiko Petrosky was fairly certain that was a substantial under estimation. And that study was BEFORE the draconian pain regime inflicted by a curiously uniform, widespread â€œmisinterpretationâ€ of the Guidelines. Just how much suffering does one endure before making the decision to end oneâ€™s own life?

This humanitarian disaster, Iâ€™m guessing, will eclipse the Tuskegee Experiment or Flint, Michigan in the annals of American medical infamy. Perhaps the CDC has determined that itâ€™s out of their hands? That they are not culpable? Iâ€™m sure that the same sentiment has been felt by many others throughout history who have opted to stand by in silence while unconscionable acts were perpetrated on the innocent. â€œSilence in the face of evil is evil itself. God will not hold us guiltless. Not to speak is to speak. Not to act is to act.â€ - Dietrich Bonhoeffer

The treatment of chronic pain patients in America is not a difference of opinion in medical treatment. It is a human rights violation."

From: Vicky Vulc
To: NCIPCBSC (CDC)
Subject: Forced tapering of pain medication kills.
Date: Tuesday, February 16, 2021 5:38:36 PM

My husband just underwent a heart procedure to find out what causes heart attack like symptoms.
Cardiologist stated that they are not caused by his heart conditions but must likely by the unmanaged pain.
Pain management is trying to reduce his high but stable dosage of opioid medication that he had been on for over 15 years.

Good work CDC!

Sent from my
iPhone

Conclusion / Adjournment

Victoria Frye, DrPh, MPH
Chairperson, NCIPC BSC
Associate Medical Professor
Department of Community Health and Social Medicine
City University of New York School of Medicine
City College of New York

Dr. Frye thanked everyone who made this meeting possible. She recognized and expressed appreciation for the presenters for their presentations and all of the work that went into each presentation, all of the CDC staff and contractors who worked so hard during this incredibly difficult period to ensure a successful meeting. She specifically called out Stephanie Wallace for documenting the proceedings, Victor Cabada for his assistance with public comments and technology, Tonia Lindley for all of her planning and coordinating, Dr. Greenspan, Dr. Houry, Dr. Cattledge, Dr. Simon, and everyone else who has been involved from CDC, the BSC members and *Ex Officios*, and members of the public. Dr. Frye indicated that she would be rotating off of the BSC and expressed gratitude for the opportunity to represent the perspectives of the people she has been working with for the last 25 years.

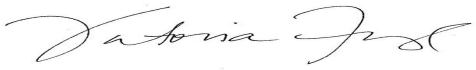
Arlene Greenspan, DrPH, MPH
Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Greenspan thanked Dr. Frye for all of her efforts, her facilitation of the BSC meetings, and agreeing to Chair this group. She expressed gratitude for Dr. Frye and everyone else who was retiring from the BSC for being a great group, and emphasized that she looked forward to continuing their relationships in new ways such as feedback, peer review, et cetera.

With no further business posed or questions/comments raised, Dr. Frye officially adjourned the Thirty-Fifth meeting of the NCIPC BSC at 4:28 PM.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the February 16, 2021 NCIPC BSC meeting are accurate and complete.



03/25/2021
Date

Victoria Frye, MPH, DrPh
Chairperson, NCIPC BSC

Attachment A: Meeting Attendance

NCIPC: BSC Co-Chairs

Victoria Frye, PhD
Associate Medical Professor
School of Medicine
City University of New York

Daniel J. Whitaker, PhD
Professor, Director
Health Promotion & Behavior
Georgia State University

NCIPC: BSC Co-Executive Secretaries

Gwendolyn Cattledge PhD, MSEH
Deputy Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Arlene Greenspan, DrPH, MPH
Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

NCIPC: BSC Members

Donna H. Barnes, PhD
Associate Professor
Department of Psychiatry and Behavior Sciences
Howard University

Roger Chou, MD
Professor of Medicine
Oregon Health and Science University
Departments of Medicine, Medical Informatics and Clinical Epidemiology

Phillip Coffin, MD
Director of Substance Use Research
Center for Public Health Research
San Francisco Department of Public Health

Chinazo Cunningham, MD, MS
Division of General Internal Medicine
Albert Einstein College of Medicine
Montefiore Medical Center

Frank Floyd, MD, FACP
Medical Director
United Health Service Medical Group

Frank A. Franklin, II, PhD, JD, MPH
Principal Epidemiologist and Director
Community Epidemiology Services
Multnomah County Health Department

Elizabeth Habermann, PhD
Professor
Department of Health Services Research
Mayo Clinic College of Medicine and Science

James Hedlund, PhD
Principal
Highway Safety North

Mark S. Kaplan, DrPH
Professor of Social Welfare
Department of Social Welfare
Luskin School of Public Affairs

Karen D. Liller, PhD
Professor
Department of Community and Family Health
University of South Florida
College of Public Health

Christina A. Porucznik, PhD, MSPH
Associate Professor
Department of Family and Preventive Medicine
University of Utah

David C. Schwebel, PhD
Associate Dean for Research in the Sciences
University of Alabama at Birmingham

NCIPC: BSC Ex Officio Members

Melissa Brodowski, PhD, MSW, MPH
Senior Policy Analyst
Administration for Children and Families

Dawn Castillo, MPH
Director, Division of Safety Research
National Institute for Occupational Safety and Health

Mindy Chai, JD, PhD
Health Science Policy Analyst
Science Policy and Evaluation Branch
National Institutes of Health
National Institute of Mental Health

Wilson Compton, MD, MPH
Deputy Director
National Institute on Drug Abuse
National Institutes of Health

CAPT Jennifer Fan, PhD
Acting Deputy Director
Office of the Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Holly Hedegaard, MD, MSPH
Senior Service Fellow
National Center for Health Statistics
Centers for Disease Control and Prevention

Lyndon Joseph, PhD
Health Scientist Administrator
National Institute on Aging
National Institutes of Health

Valerie Maholmes, PhD, CAS
Chief, Pediatric Trauma and Critical Illness Branch
National Institutes of Health
Eunice Kennedy Shiver National Institute of Child Health and Human Development

Bethany Miller, LSCW-C, MEd
Supervisory Public Health Advisor
Division of Child, Adolescent and Family Health
Health Resources & Services Administration

Judy Staffa, PhD, RPh
Associate Director for Public Health Initiatives
Center for Drug Evaluation and Research
Office of Surveillance & Epidemiology
Food and Drug Administration

RADM Kelly Taylor, MPH
Director, Environmental Health and Injury Prevention
Indian Health Service

CDC Attendees

Toni Alterman, PhD	Kathleen McDavid Harrison, PhD, MPH	Gaya Myers, MPH
Kristi Anderson, MD, MPH, FACOG	Gia Hall-Miller	Chaity Naik, MPH
Francis Annor, PhD, MPH	Mike Haffler	Jeannie Nigam, MS
Danielle Arellano, MPH	Natalie Hamilton, BS	Amanda Norris, MA
Arielle Arzu, MPH	Kischa Hampton, MS	Anika Norwood, MPH, CHES
Yulia Carroll, MD, PhD	Wendy Heirendt, MPA	Maureen Oginga, MPH
Michael Coletta, MPH	Sierra Helfrich, MPH	Jamie Osborne, MPH, CHES
Alex Crosby, MD, MPH	Ankita Henry, MPH	Parul Parikh, JD, MPH
Sarah Bacon, PhD	Jeffrey Herbst, PhD	LCDR Erin Parker, PhD
Jared Bailey	Kristin Holland, PhD, MPH	Manisha “Mo” Patel, MD, MS
Mick Ballesteros, PhD	Amy Holmes-Chavez, MPH	Cherie Peck, PhD
Angela Banks, MPH	Kelly Holton	Melissa Podolsky, MPH
Colleen Barbero, PhD	Debra Houry, MD, MPH	Lakshmi Radhakrishnan, MPH
Kathleen Basile, PhD	Rachel Hulkower, JD	Kathleen Ragan, MSPH, CHES
Sonia Berdahl, MPH	Calli Hunter, MPH	Neil Rainford, MS
Ann Berry, PhD, MS, MBA	Mohammad Islam	Minda Reed, MD, MPH
Monique Bethell, PhD, MPH	LCDR Shane Jack, PhD	Amy Reel
Joseph Bickson, PhD, MPH	Kevin Jefferson	Erica Reott, MPH

Martevia Bledsoe, MPH, CHES	Xinyi Jiang, PhD, MA	Gabriele Richardson
Robyn Borgman, MA	Akadia Kacha-Ochana, MPH	Yanet Ruvalcaba, MS
Christopher Brown, PhD, MPH, CPH	Alexis Kagiler, MPP	Sarah Roby, MPH
Loretta Brown, PhD	Jon Kim	Tracy Schaffer, MD
Andres Burgos	Jin Young Kim, MPH	Soletchi Seya
Victor Cabada, MPH	Hui Zhang Kudon, MPH	Kate Shaw, MS
Andrea Carmichael	Royal Law, PhD, MPH	Carlos Siordia, PhD
Gwendolyn Cattledge, PhD, MSEH, FACE, CHM	John Le, PharmD	Tom Simon, PhD
Alex Charleston, MPH	Kevin Jefferson	Elizabeth Solhtalab, MPA
May Chen, PhD, MSPH	Jaswinder Legha, MD, MPH	Asha Ivey-Stephenson, PhD
Brian Chin	Rachel Leavitt, MPH	Deborah M. Stone ScD, MSW, MPH
HK Chun		Ryan Tapscott, MS
Heather Clayton	Tonia Lindley	Kim Taylor
Brian Corry, MS	Ruiling Liu, PhD	Andrew Terranella
Laura Cremer, MS	Parris Lloyd, MPH	Hope Tiesman, PhD, MSPH
CAPT Christine Curtis, MD, MPH	Sarah Lowry, MPA	Allison Tracy
Linda Dahlberg, PhD	Ellen Lycan, DrPH, MA	Aimee-Rika Trudeau, MPH
Sarah DeGue, PhD	Kat Mac	Natasha Underwood, PhD, MPH
Zewditu Demissie, PhD, MPH	Karen Mack, PhD	Yamile Underwood, MPH
Jenny Dills, MPH	Reshma Mahendra, MPH	Miriam Van Dyke, PhD, MPH
Amanda Dinwiddie, MPH	Aisha Mahmood	Danny Wade, MBA
Emily Diorio	Tiffany Mallory, MPH	Andrés Villaveces, MD, PhD
		Mikel Walters, PhD
Permecia Dixon, MPH	Suzanne Marsh, MPA	Jing Wang
Kim Douglass, MPA	Susi McGhee, MPH	Rachel Ward, MSW, MPH, CHES
Linda E?	Paige McKinney	Jacqueline Watkins, MPH
Christopher Earl, PhD	Jenelle Mellerson, MPH	Enjoli Willis, DrPH, MPH
Jessica Elm	Cammie Menendez, PhD, MPH, MS	Leigh Willis, PhD, MPH
Deborah Dowell, MD, MPH	Akshara Menon, JD, MPH	Tiffany Winston
Molly Dowling, MPH, CHES	Melissa Mercado, PhD, MSc	Jessica Wolff. MPH
	James A. Mercy, PhD	Sharon Wong, MPH
Norah Friar, MPH	Christina Meyers	Shannon Woodward
Molly Gaines-McCollom, PhD, MPH	Jen Middlebrooks	LCDR Marcienne Wright, PhD
Allison Gately, MPH	Christina Mikosz, MD	Narue Wright-Jegede, MPH
		Nancy Worthington, PhD, MPH
Amanda Geller, MPH	Sasha Mital, PhD, MPH	Steven Wurzelbacher, PhD
Derrick W. Gervin, PhD, MSW		Ellen Yard, PhD
Candace Girod, MPH	Amy Molocznik	Keming Yuan, MS
Carmen Goman, PhD	Khiya Mullins, DrPH	
Arlene Greenspan, DrPH, MPH	Ashley Murray	

Public Attendees

First Name	Last Name	Organization
John	Palmieri	
Shirley	Cain	
Cindy	Herrick	2020 Mom
Melanie	Bird	AAFP
Jeanne	Tuerk	AAOMS
Zach	Laris	AAP
Marie-Michele	Leger	AAPA
Cynthia	Klein	Abt Associates
Douglas	McDonald	Abt Associates
Alicia	Sparks	Abt Associates
Joseph	Ayala	Acacia Network
Tonya	McFadden	ACOG
Arlene	Remick	ACOG
Margaret	Villalonga	ACOG
Audrey	Barker	Adena Health System
Andrew	Taubman	Adial Pharmaceuticals
Khaila	Montgomery	Administration for Children and Families
Becky	Crippen	ADPF
Leah	Sies	ADPF
Jim	Messick	ADPH
Brendan	McDermott	ADR Services
Sharonda	McNeill	ADS
David	Dooley	Advancing Parenting
Sally	Balsamo	Advocate
Michelle	Bannasch	Advocate
Tamera	Branum	Advocate
Michelle	Caccamisi	Advocate
Jen	Crews	Advocate
Tom	Hayashi	Advocate
Maria	Hill	Advocate
Marcus	Williamson	Advocate
Adrian	Delgado	AFSCME
Doreen	Marshall	AFSP
Elisabeth	Kato	AHRQ
Amanda	Krupa	AJACK CONTENT, LLC
Kyle	Perel	Akin Gump
Rachel	Kiefer	AL Department of Public Health
Jennifer	Barnhouse	Alliance for the Treatment of Intractable Pain
Richard	Lawhern	Alliance for Treatment of Intractable Pain

Mamaga Hoeflewo	Dadzi II	Ama Adoma International Foundation
Lucas	Allen	American Academy of Pediatrics
Allison	Delgado	American Academy of Pediatrics
Julie	Gorzkowski	American Academy of Pediatrics
Bonnie	Kozial	American Academy of Pediatrics
Linda	Paul	American Academy of Pediatrics
Annemarie	Matulis	American Association of Suicidology
Gary	Jackson	American Board of Family Medicine
Tim	Harless	American Chronic Pain Association
Loren	Rives	American College of Emergency Physicians
Angela	Mickalide	American College of Preventive Medicine
Connor	Jobes	American Foundation for Suicide Prevention
Christine	Moutier	American Foundation for Suicide Prevention
Natalie	Tietjen	American Foundation for Suicide Prevention
Marie	Cleary-Fishman	American Hospital Association
Joyce	Moss	American Hospital Association
Kristin	Preihs	American Hospital Association
Kelly	King	American Institutes for Research
Amanda	Latimore	American Institutes for Research
Mary	Thorngren	American Institutes for Research
Xan	Young	American Institutes for Research
Andrea	Garcia	American Medical Association
Anna	Cleese	American Medical Response
Carol	Adams	American Pain & Disability Foundation
Barton	Carey	American Pain & Disability Foundation
Michael	Hall	American Pain & Disability Foundation
Cora	Harris	American Pain & Disability Foundation
David	Israel	American Pain & Disability Foundation
Carol	Jacoby	American Pain & Disability Foundation
Johnna	Magers	American Pain & Disability Foundation
Robert	Sheerin	American Pain & Disability Foundation
Sherri	Shuherk	American Pain & Disability Organization
Stacy	Siano-Ross	American Pain & Disability Foundation
Karin	Bolte	American Pharmacists Association
Paria	Sanaty Zadeh	American Pharmacists Association
Brigid	Groves	American Pharmacists Association (APhA)
Mighty	Fine	American Public Health Association
Alec	Hermanson	American Society of Anesthesiology
Agata	Nytko	Ann & Robert H Lurie Children's Hospital of Chicago
Kim	Kaczor	Ann & Robert H. Lurie Children's Hospital of Chicago
Karlyn	Beavers	APDF

Jessamyn	Butler	APDF
Becky	Elberts	APDF
Shirley's	Galaxy A50	APDF
Pamela	Iles	APDF
A	Losket Rodgers	APDF
Charlene	McNatt	APDF
Nicole	Radi	APDF
Mike	Roberts	APDF
Nanc	Seefeldt	APDF
Christine	Shaffer	APDF
Tonya	Spencer	APDF
Linda	Frazier	APHA
Les	Fisher	APHA
Hazel	Alvarenga	Arizona Health Care Cost Containment System
Ashley	Walton	ASA
Michael	Stobbe	Associated Press
Marcus	Plescia	Association of State and Territorial Health Officials
Richa	Ranade	ASTHO
Andrea	Amderson	ATIP
Becky	Jamison	ATIP
Heidi	Sturm	Attorney at Law
Thomas	Joshua	Augusta University
Margarette	Craig	Automatic Nursing Care Agency
Diana	Meadors	BAART Community HealthCare
Miranda	Russell	BalladHealth
Daryl	Mack	Baltimore City Health Department / CRRS
Maureen	Roland	Banner Poison and Drug Information Center
Cary	Cain	Baylor College of Medicine
Michelle	Inzunza-Hall	Baylor Scott & White Grapevine Trauma Services/Injury Prevention Division
Garrett	Andrade	Baylor Scott and White
Ida	Konderwicz	Baystate Health
Donna	Bucciarelli	Beaumont Hospital, Royal Oak
Emmett	Smith	BecomingLikeWater.com
Elizabeth	Salmons	Bethany
Dr. Keely	Petty	Bethel Community Development Corporation, Inc.
Lisa	Whitling	BGSD
Lauri	Scharf	Bi-State Primary Care Association
Dena	Austin	Blue Cross Complete
Michael	Arnett	BNL Consulting
Brad	Gesek	BNL Consulting
Charles	Dunn	BNY Mellon

Eunice	Parajon	Bon Secours
Steve	LaPierre	Boston Scientific
Nilesh Patel	Patel	Boston Scientific
David	Watts	Boston Scientific
Philicia	Deckard	Brain Injury Association of Illinois
Alicia	Brav	BRAV Consultations
Jennifer	Davies	Bree collaborative
Amanda	Wyman	Bronson Methodist Hospital
Rachel	Bruce	Brunet-Garcia
Emily	Rothman	BUSPH
Christy	Aller	CORE
Elizabeth	Holland	CORE
James	Smith	CORE
Strider	Ditzler	C3 performance
Valorie	Hawk	C50/Coalition of 50 State Pain Advocacy Groups
Susan	Thau	CADCA
Devon	McGriff	California for Safety and Justice
Evan	Alden	Cannabis Strategy Unit
Carol	McDaid	Capitol Decisions Inc
Sherwin	Toyne-Stephenson	CARICOM Secretariat
Arwen	Quinn	Carilion Roanoke Memorial Hospital
Minzhi	Ye	Case Western Reserve University
Alexander	Tin	CBS
Nava	Bastola	CDCF, NY/NJ HIDTA
Monique	Bethell	CDCF-CDC-NCIPC-DOP
Renay	Bradley	CDPH
Sara	Mann	CDPH
Orion	Stewart	CDPH
Kristina	Kersting	Centene
Gayla	Perry	Center for Health and Wellness
Margaret	Hsu	Center for Substance Abuse Research (CESAR) UMD
Youb Raj	Bhatta	Central Department of Environmental Science, Nepal
Jolanda	Smith	Central Louisiana Human Services District
Amber	Rosier	Central Louisiana Human Services, LA Spirit Crisis Counseling Program
Erin	Artigiani	CESAR
Dr. Kimberly	Svevo-Cianci	Changing Children's Worlds Foundation
Doug	Douglas	Charleston Area Medical Center
Akpevweoghene	Sagua	CharLiz Healthcare Ltd
Tiffany	McClelland	Chautauqua Healthcare of Lakeview Center
Lionel	Elder	ChESS
Elizabeth	McQuaid	Chestnut Health Systems

Venisa	Green	Chicago Public Schools
Karen	Nash	Children's Health Alliance of Wisconsin
Eric	Sigel	Children's Hospital Colorado
Beverly	Canady	Chindeu Associates, LLC/ The Bridge
Sherry	White	Christus Imperial Calcasieu Surgical Center
Koa	Kai	Chronic Disease Coalition
Melanie	Grist	Chronic Illness & Pain: You Are Not Alone
Shasta Rayne	Harner	Chronic Illness Advocacy & Awareness Group
Renee	Beebe	Chronic Pain Patient
Ruth	Koznecki	Chronic Pain Patient
Gena	Struna	Chronic Pain Patient Advocate
Lynda	Rollins	Chronic Pain Patient Outreach
Phyllis	Shannon	Chronic Pain Patient Outreach
Kimberly	Smith	Chronic Pain patients
Patricia	Herbert	Chronic Pain Support
Donald	Marcello	Chronic Pain!!
Caslin	Pavy	Chrysalis Center
Peter	Denando	Church Mutual Insurance
David	Cole	CIAAG
Lauren	Deluca	CIAAG
Leah R	LoneBear	CIAAG
Jeanette	Ogle	CIAAG, National Pain Council
Janice	Garland	CIAGG
Lorrie	Ivie	Citizen
Stephen	Phillipe	City of Kenner Office of Emergency Management
Paul	Seguin	City of Ottawa Paramedic Service
William	Sims	CMS
Mark	Rosenberg	CNHF
Michelle	Price	Coalition for National Trauma Research
Ari	Davis	Coalition to Stop Gun Violence
Steven	Passik	Collegium Pharmaceutical
Mike	DeGeorge	Collegium Pharmaceuticals
Lorann	Stallones	Colorado State University
Barrye	Price	Community Anti-Drug Coalitions of America
Elizabeth	Brooks	Community Connections Inc
Eliana	Troncale	community regional medical center
Lauren	H.	Consumer Action
Sharon	Evans	Cook Children's Medical Center
Chuck	French	CORE
Ronda	Bruse	Core, PP, Advocate
Danielle	Boyd	Council of State and Territorial Epidemiologists

Mia	Israel	Council of State and Territorial Epidemiologists
Dhara	Shah	Council of State and Territorial Epidemiologists
Megan	Toe	Council of State and Territorial Epidemiologists
Jennie	Wyness	CP
Megan	Leslie	CPP
Cyndi	Lowerison	CPP
Debra	Nolan	CPP
Tilsa	Gonzalez	CSDNR
Elizabeth	Mason	CVES
Valeria	Randall	D19 CSB
Marsha	Edwards	Dallas County
Charlotte	Prather	Dayspring Logan Treatment (OTP)
Virginia	Dixon	DBHDD
Chad	Tapia	DCE Productions
Deborah	Garcia-Sandoval	Denver Juvenile Court Probation
Theresa	Owolabi	Department of Defense
Rhonda	Jackson	Department of Health Central Office
Mariel	Lifshitz	Department of Justice, Office of Justice Programs
Tracey	Spencer	Dept of Veterans Affairs
Cynthia	Kelley-Sims	Detroit Public Schools Community District
Angie M.	Leduc	DHMC
Karen	McGloughlin	DHSS/DPH
VICTORIA	FONSECA	Disabled
Brian	Williams	Disabled Chronic Pain Patient
Rudy	Flores	Division Manager, Trauma
Renee	Clark	Division of TennCare
Lolita	Miller	Doctor
Rena	Bryant	Doctors Medical Center
Kim	Ulmet	DOJ
Beverly	Diaz	Don’t Punish Pain Rally
Katrina	Fairchild	Don't Punish Pain
Melissa	Guthrie	Don't Punish Pain
Amanda	Ledford	Don't Punish Pain
Emily	Glidden	DOP
Nancy	Wheeler	DPP
Rachael	Horning	DPPR
Rachael	Horning	DPPR
Sandi	Slezak	DPPR
Jeffrey	Burkes	Dr. JR Burkes
Becky	Vance	Drug Prevention Resources (DPR)
Harry	Severance	Duke University School of Medicine

Catherine	Wolff	Duke/UNC
Nancy	Napolitano	ECRI
Lisa	Geller	Educational Fund to Stop Gun Violence
Dakota	Jablon	EFSGV
Sandra	Barr	Ehlers Danlos Society
Eileen	Jimenez	Eileen
William	Flanders	Emory University
Michelle	Stifle	Family CPP
Janine	Collier	Family Safety Center
Gail	Hayden	Farm Fresh cafes
Karen	Janiszewski	FDA
Patricia	Koussis	FDA
Stephanie	Barajas	FLDOH
Alan	Mai	Florida Department of Health
Teresa	Mathew	Florida Department of Health
Mwedusasa	Mtenga	Florida Department of Health
Michelle	Slawinski	Florida Department of Health
Amanda	Throndsen	Florida Department of Health
Dallas	Spruill	Florida Dept of Health, Epidemiology
Ingrid	Roemischer	Florida Dept. of Health - Duval County
Caitlin	Hevesy	Forbes Tate Partners
Maia	Szalavitz	Freelance
Kim	Lombard	Froedtert & The Medical College of Wisconsin
Emma	Paris	Georgia Dental Association
Elizabeth	Blankenship	Georgia Department of Public Health
Alesha	Cooke	Georgia Department of Public Health
Philip	Hudson	Georgia Department of Public Health
Chinyere	Nwamuo	Georgia Department of Public Health
Davor	Moravek	Ggzwnb
Kelly	Drane	Giffords Law Center
Gina Marie	Santorelli	Gina
Robert	Schubring	Give Pain A Voice
Ronald	Frazier	Global Garden Projects, Inc. Hope and Beyond Project
Becky	Paxton	GMG
Debra	Onufrychuk	Gonzaga College High School
Lauren	Stenger	Good Samaritan Medical Center
Elle	Kay	Grad student
Anna	Nunez	Grandview Foundation Inc.
Elizabeth	Brewer	GSK
Alli	Gitnik	Guidehouse
Jean	O'Connor	Guidehouse

Abdul	Shaikh	Guidehouse
Susan	Neurath	Guidehouse Contractor with OS/ERPO
AJ	Jelks	HALO, Inc
Elba	Scherer	HandsOn Central California
Desmond	Sakala	Harm Reduction Zambia Network
Catherine	Barber	Harvard School of Public Health
Carmen	Mitsuaysu-Gapero	Hawaii
Mary	Gombash	HCS
Cynthia	McClure	Head Start
Alma	Pula	Health Care
Mary Frances	Marlin	Health Options
Carma	Deem Bolton	Healthcare
Beatriz	Severson	Heart Property Solutions LLC
Stephanie	Booza	Henry Ford Macomb Hospital
Mitchell	Berge	HHS
Latecia	Engram	HHS
Meena	Vythilingam	HHS
Mandira	Dhar	High School
Fen	Wang	Home Care
Lillian	Ramírez-Cruz, MSN	Hospital Menonita Guayama
John	Sileo	Howard Hughes Corporation
Jessica	André	Howard University College of Medicine
Diane	Pilkey	HRSA
Rhona	Julien	HUD
Patricia	Ocasio	Hudson Valley community services
Angela	Bond	Humana
Marcella	Katjijova	Humphrey fellowship
Kayci	Rothweiler	Hunter College
Shannon	Harrer	IBM Watson Health
Frank	Yoon	IBM Watson Health
Richard	Kreis	iCare Consulting
Richard	Kreis	iCare Consulting
Robin	Davis	ICF
Nora	Kuiper	ICF
Melanie	Llinas	ICF
Maya	Payne	ICF
Hope	Sommerfeldt	ICF
Lynne	Bergero	ICF International / ASPR-TRACIE
Samantha	Cohen	ICF Next
Jackie	Dolan	ICF Next
Andrew	Kessler	ICRC

Lauren	Draftz	IDPH
Jennifer	Martin	IDPH
Alyssa	Bernido	IHS
Marco	Vences	IMSS
Paula	Schuler	Independent
Charles	Bruscino	Independent Research and Advocacy
Amnah	Anwar	Indiana Rural Health Association
Peter	Arnold	Individual
Okja	Cho	Individual
Sharon	Silveus	Individual in Pain (FM, CFS, and More)
Alan	Dellapenna	Injury Prevention Practitioner
Sharon	Nieb	Injury Prevention Research Center at Emory
Ashley	Singleton	Injury Prevention Research Center at Emory
Daniel	Beaverstock	Insite/Molson/Maple Safe Injection Sites
Audrey	Hansen	Institute for Clinical Systems Improvement
Dr. Farideh	Kioumehr	International Health & Epidemiology Research Center (IHERC)
Dena	McLain	Interstate of Hope, Inc.
Toby	Yak	Iowa Department of Public Health
Rlina	Grinfeld	ISRAEL HEALTH MINISTERY
Tiffany	Davis	IU Health Methodist Hospital
Debra	Fisher	IUE-CWA
Nicko	Kleppinger	Ivinson Memorial Hospital
Hank	Weiss	JBS International
Celeste	Putnam	JBS International
JoAnn	Roser	JBS International
Kimberly	Walsh	JBS International
MS. GG	Owens	JE DUNN CONSTRUCTION COMPANY
Danielle	Barilotti	Jersey Shore Ambulatory Surgical Center
Tracy	Nerney	Jersey Shore Regional Trauma Center
Jacquelyn	Campbell	JHU School of Nursing
Rachel	Kennedy	John’s Hopkins University
Carla	Tilchin	Johns Hopkins Bloomberg School of Public Health
Daniel	Webster	Johns Hopkins Center for Gun Violence Prevention and Policy
Cassandra	Crifasi	Johns Hopkins University
Ju Nyeong	Park	Johns Hopkins University
Mirsada	Serdarevic	JPS Health Network
Catie	Selvaggi	JPS Health Network
Mary	Contreras	JPS Health Network
Lisa	Woll	Kaiser Permanente
Ingrid	Binswanger	Kaiser Permanente Colorado

Lisa	Dau	Kapiolani Medical Center
Chris	Freedman	Karna
Vickie	Tway	Katy/West Houston Fibromyalgia & Chronic Pain Support
Steve	Sparrow	Kentucky Injury Prevention & Research Center
Dana	Quesinberry	Kentucky Injury Prevention and Research Center at University of Kentucky, College of Public Health
Genia	McKee	Kentucky Injury Prevention and Research Center, University of Kentucky
Rashid	Brown	Kingdom Fortunes Community Development Corporation, Inc
Debra	Titchenell	Kingwood Public Library
Ashley	Bush	KIPRC
Amber	Kizewski	KIPRC
Kevin	Wolf	KW&A
Nicolle	Perras	LAC
Raul	Canez	Law Office of Raúl A. Cáñez
Kerri	Gray	Lees Summit Cares
Jack	Goodman	Lewis-Burke Associates LLC
Joanna	Smith	Lighthouse Outreach Center
Trista	Gilmore	Lincoln County Public Health
Luke	Luesing	LLC
Katie	Chapman	Louisiana Department of Health
Allison	Dean	Louisiana Spirit Crisis Counseling
Loretta	Novince	LowCountry Alliance for Healthy Youth
Karen	Sheehan	Lurie Children's
Nicole	Daley	MA DPH
William	Jordison	Madison County Health Department
Gia	Ramsey	Maimonides Medical Center
Timothy	Diomede	Maine CDC
David	Clark	Maine Medical Center
Rodriguez	Rodriguez	Marc Rehabilitation
Christina	Wolf	Marietta/Belpre City Health Department
Sylvia	Hobbs	Massachusetts Center for Health Information and Analysis
ANN	HAROOTUNIAN	Massachusetts Pain Initiative
Brigitte	Manteuffel	Mathematica
April	Craig	Mayo Clinic
Tracy	Cruickshank	MCDPH
Bertha	Madras	McLean Hospital Harvard Medical School
Mary	Franks	MDHHS
Jessica	Grzywacz	MDHHS
David	Hirsch	MDM
Lorena	Smith	Me

Jeanne	Hart	Medical Assistant
Jinnifir	Gauerke	MEDICAL CITY PLANO
May	Amolat-Apiado	Medical Examiner
Rachele	Solomon	Memorial Healthcare System
Barbara	Blair-Reade	Mercy Medical
Cynthia	Thompson	Meridith Rose Foundation for the Humanities
Misty	Brantley	MGCAA
Misty	Brantley	MGCAA
Rachel	Zaguskin	Michigan Department of Health and Human Services
Denise	Delorie	Mid Maine Substance Use Prevention Coalition
Joy	Griffin	Millennium
Courtney	Geiger	Milwaukee Health Department
Annette	Maxwell	Mings Medicinals
Jason	Peterson	Minnesota Department of Health
Mira	Sheff	Minnesota Department of Health
Diana	Linn	Mission Hospital
Marci	Mednick	Mission Hospital
Emily	Jones	MNPS
Angela	Molden	Molden
Sharon	Quayle	Montefiore Medical Center
Linda	McGlone	Monterey County Health Department
Corrinna	Martin	Mothers Of Victim's Equality Inc.
Terese	Thornton	Mount Carmel Health Systems
Jamie	Bey	Mountain View LLC
Irene	Hansen	Ms. Hansen
Shawn	Crowley	MUSC
Christa	Green	MUSC Children's Hospital
Jenny	Woodward	Myself
Annie	Clask	N/A
Joe	Dudley	N/A
Anne	Fuqua	N/A
Sandra	Stanley	N/A
John		NA
Kabaye	Diriba	NACCHO
Jennifer	Li	NACCHO
Caroline	Snyder	NACCHO
Lance	Marshall	NAMI
Caprice	Edwards	NAPHSIS
Shae	Sutton	NAPHSIS
Amy	Partridge	National Advocate
Robert	Morrison	National Association of State Alcohol and Drug Abuse Directors

Dia	Gainor	National Association of State Emergency Medical Services Officials
Alyssa	Schatz	National Comprehensive Cancer Network
Tahra	Johnson	National Conference of State Legislatures
Charlie	Severance-Medaris	National Conference of State Legislatures
Jane	Pearson	National Institute of Mental Health
Tina	Medved	National Institute of Public Health (NIJZ)
Leah	Ettman	National Network of Public Health Institutes
Misty	Hoffman	National Pain Council
Karla	Rabel	National Pain Council, CIAAG
Emily	Ullrich	National Pain Council
Michael	Greene	National Prevention Science Coalition
Brian	Callahan	National Safety Council
Rachael	Cooper	National Safety Council
Sergey	Sinelnikov	National Safety Council
Jennifer	Grove	National Sexual Violence Resource Center
Shana	Geary	NC Department of Health and Human Services, Division of Public Health
Anne	Geissinger	NC Dept of Public Health
Glorina	Stallworth	NC DHHS
Amanda	Isac	NC Division of Public Health
Ingrid	Bou-Saada	NC Division of Public Health, Injury and Violence Prevention Branch
Brenda	McDonald	NCAP Early Head Start
Jane	Miller	NCDHHS
Lindsay	Baran	NCIL
Amanda	Consigli	NEHIDTA
Julia	Dugery	Network of Victim Assistance
Kit Bing	Yick	New Brunswick Public School
Kathryn	Lowerre	New Mexico Department of Health
Francesca	Sullivan	New York Presbyterian Queens
Michael	Bauer	New York State Department of Health
Sheila	Kaplan	*New York Times*
Kelly	Janese	Niagara Community Action Program
Cinnamon	Dixon	NICHD
Cinnamon	Dixon	NIH - NICHD
Chyna	Locklear	NIHB
Stephen	O'Connor	NIMH
Farris	Tuma	NIMH/NIH
Katharine	McGreevy	NJDOH
Annette	Wallace	NKY Health
Lesli	Messinger	No More ODs
Susan	Sluder	No Organization

Nan	Branham	None
Debbie	Emmel	None
Amanda	Hand	None
Tesa	Hayashi	None
Roger	Holland	None
Ruth	Koznecki	None
Irene	Mitchell	None
Nilesh	Patel	None
Candance	Principe	None
Brett	Harris	NORC
Christina	Drymon	NORC at the University of Chicago
Tracy	McPherson	NORC at the University of Chicago
Kathleen	Scott	North Tx Institute of Neurology and Headache
Michele	Farry	Northampton Health Department
Jackie	Payne	Northeast Georgia Medical Center
Olúgbémiga "Olú"	Ẹ́kúndayọ̀	Northern Kentucky University
Maryann	Mason	Northwestern University, Feinberg School of Medicine
Pamela	Damon	Not On My Watch NOMW
Jonathan	Kassa	NOVA Bucks
Jessica	Lavoie	NPC
Kacie	Seil	NYC DOHMH
Consuelo	Dungca	NYC H+H/Metropolitan
Kelly	Ramsey	NYS OASAS
Kathy	Leibowitz	NYU College of Dentistry
Tasha	Bailey	Ocean County College
Patrick	Robinson	ODG by MCG
Yaina	Perdomo	Office of Preparedness and Response Puerto Rico Department of Health
Stephen	Wright	Office of U.S. Senator Tom Cotton
Taunia	Couch	Ogden Regional Medical Center
Elena	Acuna	Ogilvy
Rohan	Verma	Ogilvy
Jessica	Fitzgerald	Ogilvy
Ali	Hamade	OHA
DEFIORE	JOLENE	Ohio Department of Health
Tamarine	Foreman	Ohio University
Teresa	Poliseno	OhioHealth
Adrienne	Gallardo	OHSU Doernbecher Children's Hospital
Robyn	Brooker	Oil of Worship Ministries
Lorry-Gail	Malcom	Oklahoma State Department of Health
Tracy	Wendling	Oklahoma State Department of Health
Helen	Hernandez	ONDCP

Ken	Smith	Op Inc
Shelly	Armstrong	OPA
Natalie	Greene	On Par Productions (OPP)
Stephanie	Wallace	On Par Productions (OPP)
Tammy	Sanchez	Open Arms Rape Crisis Center & LGBT+ Serv
Jennifer	Gonzales	Orange County Global Medical Center
Julie	McFarlane	Oregon Health Authority
Drew	Allen	Oregon Health Authority - Public Health Department
KeKe	Debebe	OSI
Patrick	Martens	P & M Professional Services, Inc.
Kari	Kruska	P3
Tamera Lynn	Stewart	P3
Julia	Heath	P3 Political Alliance
Grace	Karis	PA
Ashley	Rodgers	PA Alliance for Chronic Illness & Pain
Carrie	Goetz	PA DOH
Cindi	Lewis	PACT Head Start
John	Schoellman	Pain
Lee	Egger	Pain Advocacy
Duane	Pool	Pain Advocacy Coalition
Michael	Hause	Pain GT
Angie	Goodgame	Pain Nation LLC
Pat	Anson	Pain News Network
Jean	Phillips	Pain News Network
Kathleen	Bowers-Pinette	Pain Patient
Clare	Rhodes	Pain Patient
John	Schoellman	Pain Patient
Karen	Tuthill	Pain Patient
Carol	Benack	Pain Patient Advocate
Carrie	Judy	Pain Researcher
Katie	Clark	painfullyliving.com
Dora	Winters	PainMatters
Jim	Nowicki	Palantir
Courtney	Edwards	Parkland Health & Hospital System
Robyn	Oster	Partnership to End Addiction
Carol	Limahelu	Patient
Serina	Matteson	Patient
Hillary	Dummer	Patient
Dale	Barnes	Patient Advocate
Beth	Larson	Patient Advocate/Caregiver
S "Maggi"	Stebbins	Patient Human Being

Virginia	Brandford	Patient With Rare Disease
Cammie	LaValle	Patient/Advocate
Scot	Faulkner	PBM Foundation
Susan	Klarich	PBSO
Susan	Cruz	PDS
Karen	Black	Personal
Jody	Harness	Personal
Andrea	Graves	Personal Experience & Growth
Katie	Eichelbaum	Personal Interest
Pío	G. GOWLAND	PGG
Lisa	Hines	Pharmacy Quality Alliance
Hollie	Watson	Pima County Health Department
Angie	Reed	PMC
ROCHELLE	ODELL	PNN
Danielle	Krushnic	Portland VA Health Care System
Peter	Pischke	Post Millennial
LINDA	LARAS	PR HEALTH JUSTICE CENTER, SAN JUAN BAUTISTA SCHOOL OF MEDICINE
Terri	Lewis, PhD, NCC	Practical Pain Management
Steven	Forsyth	Preferred Family Healthcare
Alisha	Somji	Prevention Institute
Dianna	Byrne	Private
Doryn	Chervin	Private
Jay	Kasten	Private
Jennifer	McClendon	Private Practice
Laura	Newman	Providence Intervention Center for Assault and Abuse
Julie	Mackie	Providence- Mission Hospital
Georginne	Mercado	Providence Mission Hospital Trauma Center
Daniel	Busch	Psychiatric Associates, S.C.
Sarah	Johnson	Public Health Madison & Dane County
Aurielle	Smith	Public Health Madison and Dane County
Wanda	Ocasio Nelson	Purdue Extension Marion County
Lynetta	Parrott	Purple Cross Ministry
Rebecca Anne	Pierce	Rebecca
Marilyn	Diamond	Remnant of Grace Outreach
Barbara	Schalk	Representing myself
Leslie	Bythewood	Retired
Mike	Landen	Retired
Sonia	Swearomgem	Retired
William	Aiken	Retired (Active) RN (Emergency)
Peggy	O'Connor	Retired, C.O.R.E.
Jeffrey	Hill	Rhode Island Department of Health

Hassan	Burush	RIO
Daryl	Mullee	RN
Lydia	Watts	ROAR
Ruthanne	McCormack	Rockville Centre Coalition for Youth
Stacey	Fields	Roots and Petals
Nicole	Davis	Rough Angels On love's Corner'ed
Gregory	McDonald	RTI International
Carianne	Muse	RTI International
Andy	Peytchev	RTI International
Carolina	Barbosa	RTI International
Georgiy	Bobashev	RTI International
Jessica	Cance	RTI International
Lisa	Carley-Baxter	RTI International
Elvira	Elek	RTI International
Dalia	Khoury	RTI International
Linda	Squiers	RTI International
Jessica	Williams	RTI International
Gary	Zarkin	RTI International
Stephanie	Bonne	Rutgers New Jersey Medical School
MURIEL	BRAZEAU	Safe Haven
Pam	Ford	Safe Kids Greater South Haven
Richard	Hamburg	Safe States Alliance
Shelli	Stephens-Stidham	Safe States Alliance
Kristy	Duritsch	Safety Council of Southwestern Ohio
Heidi	Israel	Saint Louis University
Paul	Coelho	Salem Health
Dr. Gregora	Salazar	Salud Publica Sud America
Chelsey	Morris	SAM
Dona	Dmitrovic	SAMHSA
Traci	Pole	SAMHSA
Deborah	VanOlst	San Mateo County Health
Grayce	Niles	Sandy Hook Promise
Michele	Storbeck	Sanford Jackson
Adam	Sadewasser	SASCC
Achamelysh	Demissie	Save To Save Organization (NGO)
Marlene	Al-Barwani	SC DHEC
Brooke	McKearn	School District of Beloit
Sandra	Alexander	SciMetrika in the Division of Violence Prevention at CDC
Herbert	Ruderman	SCPS
John	Crines	Scripps Health
MARCIO ACCIOLY	FOSSARI	Secretaria Municipal de Saúde

ABUBAKR	ABDALLA	SEHA
Erica	Altheide-Nielson	Self
Robert	Angus	Self
Michelle M	Betts	Self
Joel	Cohen	Self
Christine	Doner	Self
Mindy	Ellis	Self
Rebecca	Fouts	Self
Julie	Glatczak	Self
Deborah	Jones	Self
Lisa	Kronus RN	Self
Terri	Lewis	Self
Kristin	McGarity	Self
Jonathan	Meadows	Self
Luke	Michaelson	Self
Kathleen	Oakes	Self
Noelle	Pastor	Self
Fitzgerald	Providence	Self
Charlotte	Revelo	Self
Megan	Rivera	Self
E	Rose	Self
Kathleen	Sabo	Self
Len	Schwalm	Self
PAMELA	STEVENSON	Self
Charles	Williams	Self
Nancy	Witherill	Self
Julie	Litten	Self (retired PA)
Vinita	Garnier	Self-Employed Social Worker
Daniel	Elchert	Senate Health, Education, Labor and Pensions
Noemi	Gonzalez Casalegno	SEP
Dr. Ashutosh Kumar	Sharma	Sharma Family Medicine and Palliative Care Unit
Jeff	Van Ausdall	Shasta County Health and Human Services Agency
Girma	Beyan	Sheer Media
Soha	Al Marsafy	Sheikh Zayed specialized hospital
Tunishia	Kuykindall, MS	Shelby County Tennessee Health Department
Barrett	Cisney	Sheppard Pratt
Umberto	Nizzoli	SISDCA
Jodi	Fiocchi	SMH
Matt	Tribble	South Dakota Department of Health
Stacey	Carroll	Southern NH Health
Sloan Bruan	Lorenzini	Special Needs Solution

Raman	Kaneria	Springfield hospital center
Gihan	Anthony	St. Anthony Medical CENTERS
Krista	Norrid	St. John Trauma
Anita	Barksdale	St. Joseph Mercy Oakland
Sherry	Johnson	St. Mary's Medical Center
Utoomporn	Sittisingh	St. Theresa International College
Sheri	Owen	Stand By Me In Pain
Beth	Darnall	Stanford University
Cameron	Kieffer	State Department
Ken	Fealing	StormCenter Communications
Diane	Shaheen	Student at Massachusetts College of Liberal Arts
Hajaratu	Tohomdet	Student: PHD Gender Based Violence (GBV)
Tarsyia	Waddell	Tarsyia Waddell
Nancy	Cook	Taylor Regional Hospital
Tony	Garr	Tennessee Health Care Campaign
Kristen	Beckworth	Texas Children's Hospital
Diane	Kaulen	Texas Children's Hospital
Haruna	Miyakado	Texas Department of State Health Services
Jennifer	Haussler Garing	Texas HHSC
Stan	Rosen	THCCP
Jennifer	Aubrey	The Center for Integration, Inc.
Suzanne	Nesbit	The Johns Hopkins Hospital
Timothy	Daly	The Joyce Foundation
Nina	Vinik	The Joyce Foundation
Lori	Cassity Murphy	The Medical Association of Georgia (MAG)
Jenna	Bluestein	The Pew Charitable Trusts
Sheri	Doyle	The Pew Charitable Trusts
Nilda	Nieves	The Prevention Council of Putnam
Tina	Donayri	The Queen's Medical Center
Terri	Schreiber	The Schreiber Research Group
Nancy	Alvarez	The University of Arizona College of Pharmacy - Phoenix
Stephanie	Smith	The Vesta Project
Kathi	Hegranes	ThedaCare Regional Medical Center-Neenah, Trauma Services
David	Sleet	TJ FACT
BRITTANEY	JENKINS	TN POISON CENTER
Jean	Haughey	Town of Enfield Youth & Family Services
Valerie	Khouri	Training
Baljinnyam	Javzankhuu	Training and Research Institute on child rights of Mongolia
Jennifer	Ward	Trauma Center Association of America
Mar	Butler	TREE Leadership

Amber	Emerson	Trinity Health
Andrea	Maresca	TRP
Jonah	Cunningham	Trust for America's Health
Susan	Gallagher	Tufts Medical School
Phyllis	Agran	UC Irvine and American Academy of Pediatrics - Orange County CA
Agnieszka	McCort	UNC Injury Prevention Research Center
Laura	Pressler	United Regional Health Care System
Ann	Coker	Univ of Kentucky
Rosario	Cárdenas	Universidad Autónoma Metropolitana
Natasha	Ashcraft	University Hospital
Ana	Acosta	University Medical Center of El Paso
Marybeth	Curtis	University of Arkansas for Medical Sciences
Delfa	Seto	University of California, Irvine Medical Center
Jamila K.	Stockman	University of California, San Diego
Regina	Menninger	University of Cincinnati Medical Center
Emmy	Betz	University of Colorado School of Medicine
Chiara	Sabina	University of Delaware
Yanning	Wang	University of Florida
Kari	Harland	University of Iowa
Terry	Bunn	University of Kentucky
Haruna	Habu	University of Maiduguri Nigeria
Mona	Mittal	University of Maryland
Jessica	Roche	University of Michigan Injury Prevention Center
Chris	Kelly	University of Mississippi Medical Center
Bruce	Harry	University of Missouri School of Medicine, Department of Psychiatry
Ashley	Raposo-Hadley	University of Nebraska Medical Center
Theresa	Cruz	University of New Mexico
Mark	Van Ryzin	University of Oregon
Douglas	Wiebe	University of Pennsylvania
Anthony	Fabio	University of Pittsburgh
Eric	Caine	University of Rochester Medical Center
Ismael	Hoare	University of South Florida
Glenn	Barnes	University of Texas at Tyler
Angela	Di Paola	University of Texas Health Science Center
Annalyn	DeMello	University of Texas Medical Branch
Kirby	Thierheimer	University of Texas Medical Branch
Gregory	Terman	University of Washington
Erica	Wasmund	University of Washington
Helen	Sisneros	UNM hospital
Tina	Hamilton	UPPER DARBY RECOVERY WITHOUT BARRIERS

William	Simmons	UPS
Liliana	Velez	Urban Resource Institute
Mark	Kinzly	Urban Survivors Union
Nicole	Hemmenway	US Pain Foundation
Cindy	Steinberg	US Pain Foundation
Opal	Richard	USA
Fern	Kolarik	USACRPS
Chris	Ursino	USN
Teresa	Brechlin	Utah Department of Health
Haylee	Parsons	Utah Pain Patient Advocates
Jed	Wright	Utah Pain Patients Advocates
Dennis	Cecchini	Utah Substance Use and Mental Health Advisory Council.
Mary	Lauby	UW Health
Stephen	Okeyo	Uzima University, Kisumu
Tomi	St Mars	Valleywise Health
Anne	Zehner	VCU
Melanie	Cook McCant	Veritas Management Group
Felicia	LaPoole	Veritas Management Group
Laura	Abbott	Victims' Rights Arkansas
Laura	Veach	Wake Forest School of Medicine
Alysa	Fornarotto-Regenye	Wall High School
Rose	Bigham	Washington Patients In Intractable Pain
Wayne	Parsons	Wayne Parsons Law Office
R	Clayton	WCF
Rose	Knechtel	Well Care Health LLC
Kaitlin	Bechtel	WellSpan Health York Hospital
Haley	Stokes	Wellstar Kennestone Trauma
Cheryl	Kolb	West Central Health District
Chanza	Baytop	Westat
David	Marker	Westat
Kerry	Morrissey	Westat
Patricia	Shifflett	Westat
Iris	Galvan	Whitecoat Clinic
Pamela	Imm	WI Depart of Health Services
Gail	Malloy	Wilkes-Barre General Hospital
Mik	Taylor	Wings of Hope
Heejune	Chang	Winnipeg Regional Health Authority
Steven	Wright, MD	Wright Medical, LLC
Yohiris	Martin	YM Family Counseling Services LLC
Amie	Simeral	YWCA
Julie	Goldstein Grumet	Zero Suicide Institute

Nicholas	Ancona	Zero Suicide Institute
Chris	Freedman	Zero Suicide Institute
Elizabeth	Kim	Zero Suicide Institute
Jonathan	McGrath	Zero Suicide Institute
Jim	Nowicki	Zero Suicide Institute
Jamila	Porter	Zero Suicide Institute

Attachment B: Acronyms Used in This Document

Acronym	Expansion
AAIHB	Albuquerque Area Indian Health Board
ACEs	Adverse Childhood Experiences
ADS	Associate Director for Science
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indians and Alaska Natives
AJPM	*American Journal of Preventive Medicine*
APHA	American Public Health Association
BIG	Blacks in Government
BRFSS	Behavioral Risk Factor Surveillance System
BSC	Board of Scientific Counselors
CAN	Child Abuse and Neglect
CBPR	Community-Based Participatory Research
CCJ	National Commission on COVID-19 and Criminal Justice
CDC	Centers for Disease Control and Prevention
CIOs	Centers, Institutes, and Offices
COD	Committee on Diversity
COD	Cause of Death
CPSC	Consumer Product Safety Commission
CSTE	Council of State and Territorial Epidemiologists
DIP	Division of Injury Prevention
DoD	Department of Defense
DoDSER	Department of Defense Suicide Event Report
DOP	Division of Overdose Prevention's
DOSE	Drug Overdose Surveillance and Epidemiology System
DVA	Department of Veterans Affairs
DVP	Division of Violence Prevention
EAP	Employee Assistance Program
ED	Emergency Department
EEO	Equal Employment Opportunity
EOC	Emergency Operations Center
ERPO	External Research Program Office
ESOOS	Enhanced State Opioid Overdose Surveillance
ET	Eastern Time
FACA	Federal Advisory Committee Act
FARS	Fatality Analysis Reporting System
FASTER	Firearm Surveillance Through Emergency Rooms
FOA	Funding Opportunity Announcements
FRED	A Framework for Reconstructing Epidemiological Dynamics
FY	Fiscal Year
GBG	Good Behavior Game
GLITC	Great Lakes Inter-Tribal Council
GPTCHB	Great Plains Tribal Leaders Health Board
GRADE	Grading of Recommendation Assessment, Development, and Evaluation
HAN	Health Advisory Notice
HBCUs	Historical Black Colleges and Universities

Acronym	Expansion
HCP	Healthcare Providers
HHS	(United States Department of) Health and Human Services
HIDTA	High Intensity Drug Trafficking Areas
HRO	Human Resources Office
ICARIS	Injury Control and Risk of Injury Survey
ICD-10-CM	International Classification of Diseases-10-Clinial Modification
ICRC	Injury Control Research Center
IHB	Indian Health Boards
IHS	Indian Health Service
IPV	Intimate Partner Violence
JAMA	*Journal of the American Medical Association*
LGBTQAI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+
ME	Medical Examiner
MME	Morphine Milligram Equivalents
MMWR	*Morbidity and Mortality Weekly Report*
MSIs	Minority-Servicing Institutions
NAS	National Academy of Sciences
NASEM	National Academy of Sciences, Engineering, and Medicine
NCBH	National Council for Behavioral Health
NCHS	National Center for Health Statistics
NCIPC	National Center for Injury Prevention and Control
NEDS	Nationwide Emergency Department Sample
NEISS	National Electronic Injury Surveillance System
NEISS-AIP	National Electronic Injury Surveillance System–All Injury Program
NEJM	*New England Journal of Medicine*
NFISS	Nonfatal Firearm Injury Surveillance Study
NFLIS	National Forensic Laboratory Information System
NHTSA	National Highway Traffic Safety Administration
NICHD	National Institute of Child Health and Human Development
NICS	National Instant Criminal Background Check System
NIDA	National Institute on Drug Abuse
NIH	National Institutes for Health
NIJ	National Institute of Justice
NIMH	National Institute for Mental Health
NIOSH	National Institute for Occupational Safety and Health
NISVS	National Intimate Partner Violence and Sexual Violence Survey
NLP	Natural Language Processing
NOFO	Notice of Funding Opportunities
NPAIHB	Northwest Portland Area Indian Health Board
NSCH	National Survey of Children's Health
NSDUH	National Survey on Drug Use and Health
NSSP	National Syndromic Surveillance Program
NVDRS	National Violent Death Reporting System
NVSS	National Vital Statistics System
OD2A	Overdose Data to Action
ODMAP	Overdose Detection Mapping Application Program
OGC	Office of General Council
OGS	Office of Grants Services

Acronym	Expansion
ONDCP	Office of National Drug Control Policy
OPMO	Office of Program Management and Operations
ORCU	Opiate Response Coordinating Unit
OSI	Office of Strategy and Innovation
OUD	Opioid Use Disorder
PIEB	Program, Implementation, and Evaluation Branch
PPE	Personal Protective Equipment
PWUD	People Who Use Drugs
RMTLC	Rocky Mountain Tribal Leaders Council
RPE	Rape Prevention and Education
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SNOMED	Systematized Nomenclature of Medicine
SUD	Substance Use Disorder
SV	Sexual Violence
TA	Technical Assistance
TECs	Tribal Epidemiology Centers
UIHI	Urban Indian Health Institute
UK	United Kingdom
US	United States
WG	Workgroup
WISQARS™	Web-based Injury Statistics Query and Reporting System
YAM	Youth Aware of Mental health
YRBS	Youth Risk Behavior Survey
YRBSS	Youth Risk Behavioral Surveillance System
YV	Youth Violence