NCIPC Board of Scientific Counselors
Open Session
August 20, 2020

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
BOARD OF SCIENTIFIC COUNSELORS (BSC)
Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)

Thirty-Fourth Meeting
August 20, 2020

Teleconference Meeting
Open to the Public

Summary Proceedings

The Thirty-Fourth meeting of the National Center for Injury Prevention and Control (NCIPC; Injury Center) Board of Scientific Counselors (BSC) was convened on Thursday, August 20, 2020 via teleconference and Adobe Connect. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA).

Call to Order / Roll Call / Meeting Process / Welcome & Introductions

Call to Order

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-Fourth meeting of the NCIPC BSC at 10:00 AM Eastern Time (ET) on Thursday, August 20, 2020.

Roll Call / Meeting Process

Mrs. Tonia Lindley
NCIPC Committee Management Specialist
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Mrs. Lindley conducted a roll call of NCIPC BSC members and *Ex Officio* members, confirming that a quorum was present. Quorum was maintained throughout the open portion of the teleconference. One conflict of interest (COI) was declared by Dr. Compton who indicated that he has long-term stock holdings in General Electric, Pfizer, and 3M Companies. An official list of BSC member attendees is appended to the end of this document as Attachment A. Mrs. Lindley introduced Stephanie Wallace, the Writer/Editor from Cambridge Communications and Training Institute (CCTI), who she explained would record the minutes of the meeting. To make it easier for her to capture the comments, Mrs. Lindley requested that everyone state their names prior to any comments for the record. She indicated that the CDC Audio Technician and that in addition to the minutes, the meeting also would be audio recorded for archival purposes to ensure accurate transcripts of the meeting notes. The meeting minutes will become part of the official

record and will be posted on the CDC website at www.CDC.gov/injury/bsc/meetings.html. All NCIPC BSC and *Ex Officio* members were requested to send an email to Mrs. Lindley at ncipcbsc@cdc.gov at the conclusion of the meeting stating that they participated in this meeting.

Welcome & Introductions

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 expressed sincere gratitude to everyone and thanked them for their time and commitment to injury and violence prevention, recognizing that everyone is busy and was taking time out of their schedules to provide advice to the leadership of CDC and NCIPC on injury and violence prevention research and programmatic activities. She also thanked and welcomed members of the public, whose engagement is very much appreciated and is critical to the BSC's role and mission. She noted that from 12:20 PM to 1:00 PM, there would be a period for public comment, at which time the operator would provide instructions to anyone wishing to make a public comment. Those unable to present their public comments during the call were invited to submit them in writing to ncipcbsc@cdc.gov. There will be additional opportunities to comment on ongoing opioid activities. For those on the phone without Adobe Connect access, the presentation slides were made available at https://www.cdc.gov/injury/bsc/meetings.html. Dr. Frye indicated that she was informed that she would need to leave the BSC meeting at 11:00 AM for an urgent and unchangeable institutional commitment and that Dr. Daniel Whitaker, NCIPC BSC Co-Chair, had graciously agreed to facilitate the remainder of the meeting at that time.

Approval of Last Meeting Minutes

Dr. Frye indicated that typically at this point, the NCIPC BSC members would vote on approval of the minutes from the prior meeting. However, the last meeting minutes were not yet available given the close proximity of the previous meeting to this meeting. Therefore, this agenda item will be deferred to the next meeting.

NCIPC Director's Update
Diversity and Inclusion: A Commitment

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

Dr. Houry said that given the recent acts of violence and protests in our country, as well as the call to action from the NCIPC BSC during the last in-person meeting to discuss health equity and disparities further, she would focus this session on discussing CDC's emphasis on creating equitable and inclusive environments. In public health, there is a lot of discussion about social determinants of health (SDOH) impacting health equity. The environments in which people are born, live, and work may affect a wide range of health risks and outcomes. However, racism and inequities have been a public health issue that have been present for far too long. Everyone has a role to play in moving toward a more equitable society. Actionable changes need to be made for current and future generations. Thought must continue to be given to where these acts can

be prevented from happening early, where to intervene to prevent further harms, and how to support those who have been harmed. While CDC has been working on these issues over the years, the recent events have heightened the need for the agency to do much more.

To effectively address racial health inequities in the community CDC serves, it is critical to look within the agency with a focus on implicit and explicit biases in the workplace. CDC has made an agency-wide commitment to improving diversity and inclusion in its workplace. Senior leadership (e.g., CDC Director, his direct reports, and all of the Center Directors) developed steps to improve and communicate progress through a few key items as follows:

- Leadership: This includes CDC's Diversity and Inclusion Executive Steering Committee. This Steering Committee is Co-Chaired by Dr. Schuchat, CDC's Principal Deputy Director, and Dr. Leandris Liburd, the Associate Director for CDC's Office of Minority Health and Health Equity (OMHHE).

- Best Practices: Best practices are shared from within each Center so that they can learn from each other and continue to leverage the strengths throughout the agency.

- Partnerships: This element focuses on Historically Black Colleges and Universities (HBCUs) and other college programs to enhance pipeline and training programs.

- Support and Services: Support and services through the Human Resources Office (HRO) will be developed through increased funding for this office to support recruitment and retention to increase the diversity of CDC staff through new hires.

- Accountability: This key item focuses on ensuring that supervisors take unconscious bias training throughout the agency, beginning with senior leadership.

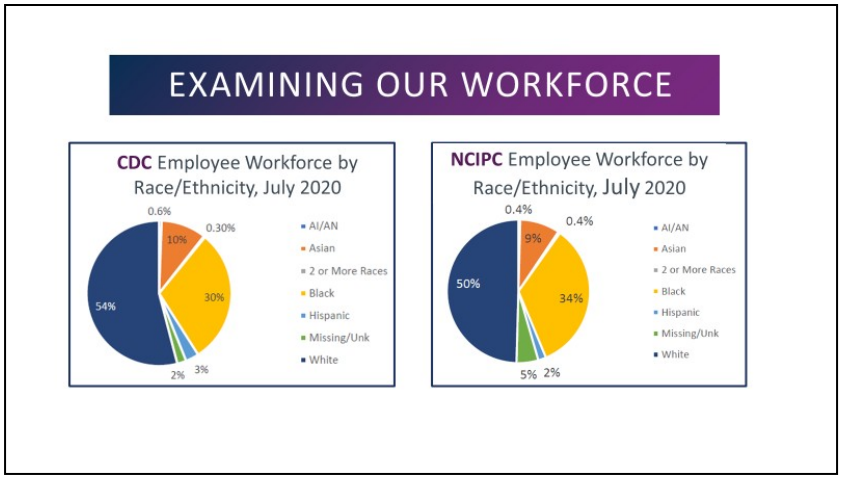
- Scientific Efforts: The focus of this element is on enhancing research opportunities to deepen the understanding and identify effective interventions to reduce disparities and achieve health equity. For instance, Dr. Michelle Williams, Dean of the Faculty for Harvard T.H. Chan School of Public Health, will serve as the keynote speaker for this year's Charles C. Shepard Science Award—CDC's version of the Oscars. Dr. Williams will discuss racism as a public health crisis.

- Communication: The intent of this key item is to improve internal transparency and awareness of the activities underway. There will be regular updates on the CDC intranet so that staff are aware of progress on these activities.

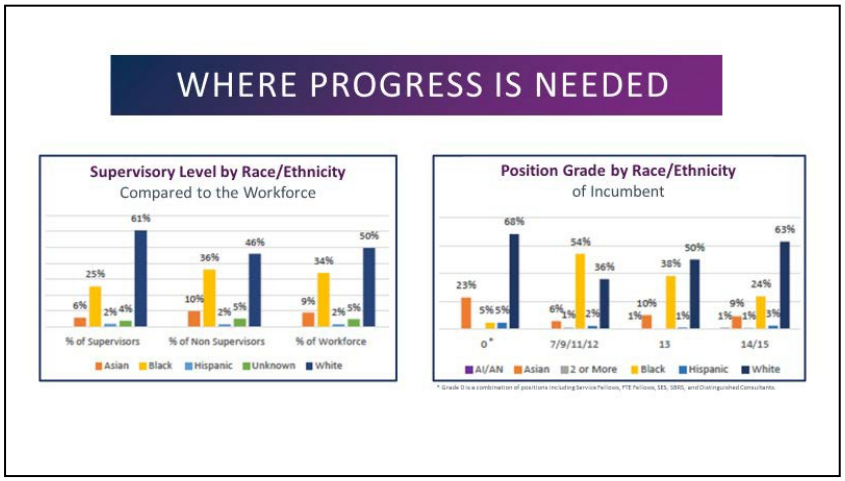
NCIPC continues to place an intentional focus on building and fostering resiliency and creating space for dialogue. Recognizing that each individual is impacted in a different way from these injustices, the Injury Center's first priority following the recent events was to ensure that staff felt supported and that space was created for dialogue. Dr. Houry emailed all staff and partners following the events and provided thoughts on how these events related to their work and steps they could take. Later in June, she sent out information on Juneteenth along with resources for further information for NCIPC staff to engage in how to address racism and unconscious bias and understand the inequities that many of their colleagues face on a daily basis. They also convened two resiliency listening sessions with CDC's Employee Assistance Program (EAP) to talk about the recent event. These received a large turnout of staff and NCIPC is grateful for the raw emotions and stories shared. NCIPC led that effort for the agency and at that time was the only CIO (Centers, Institutes, and Offices) facilitating these sessions. Now they are being

replicated across the agency. It is important for CDC to continue to establish an environment in which staff can feel safe, heard, and respected. They must honor and respect how each other are feeling. This is a challenging time for individuals at home, at work, and in the community.

Staff diversity continues to be a priority for the Injury Center. NCIPC recently completed its Fiscal Year 2020 (FY20) Workforce Diversity Report. This is derived from voluntarily disclosed data from fulltime employees (FTEs). Data are often missing for Commissioned Corp Officers and are not available for non-FTE fellows or contractors. While this does not represent the entire workforce, it is the best available data that they have. NCIPC's workforce has grown by 43% over the past 4 years with the growth of many of its programs. During that time, the percentages of Asian Pacific Islanders, Hispanic, and Black employees also has increased for a combined total of 45%. NICPC's numbers are comparable to CDC's as a whole as depicted in the following pie charts:



While NCIPC is proud of the diversity represented across the Injury Center, work is needed to increase diversity among leadership and supervisory positions. The number of supervisory positions in the Injury Center has been increased by 50%, which results in a total of about 23% of NCIPC's FTEs serving in a supervisory position. However, as illustrated in the graphs below, racial and ethnic minorities are not well-represented in supervisory roles nor are they represented at the same level in the higher position grades:



These data have been shared with the Injury Center staff as well. NCIPC is taking a comprehensive and inclusive approach to increase diversity among its leadership staff. This starts with investing in the current workforce to ensure growth potential, training, opportunities for promotion, and reaching out to talented workforces outside of the Injury Center and outside the government through partnerships with HBCU, Hispanic-Serving Institutions (HSIs), Tribal Communities, and other organizations. One immediate equitable opportunity for leadership positions GS-14 through GS-15 is by ensuring that hiring panels are diverse in terms of race, ethnicity, gender, and inclusion of panel members from outside of the Injury Center when possible. NCIPC is in the process of developing a Standing Operating Procedure (SOP) to further ensure diverse representation on hiring and selection panels. In the meantime, Dr. Houry and both Deputy Directors are reviewing proposed panelists for all leadership positions to ensure that this diversity is maintained.

NCIPC also is working to identify an external consultant to assess the Injury Center's diversity and facilitate NCIPC in ensuring an inclusive culture. The external consultant will assess NCIPC's internal processes for hiring, development of the leadership pipeline, and promotion and retention. This will be accomplished through interviews and focus groups with leadership and staff. The Injury Center has spoken with several consultants and hopes to finalize the subcontract by the end of August 2020. It is critical that diversity is reflected among NCIPC's leadership and staff diversity is a priority of the Injury Center to ensure a workforce with a range of experienced and perspectives required to advance its work and mission.

The Injury Center's workgroups (WGs) have been instrumental in keeping a focus on equity among NCIPC and its work. Dr. Houry highlighted a few of these WG as follows:

- The Committee on Diversity (COD) coordinates and promotes the Injury Center's diversity and inclusion processes and activities. They organize a number of events and activities throughout the year. For instance, they recently organized an unconscious bias training. They also have a Recruitment and Retention Subcommittee that supports efforts to address and improve upon diversity inclusion topics within NCIPC's workforce.

- The Race and Violence Workgroup (RVW) focuses on inequities and provides opportunities for staff engagement. They are updating a training for the Division of Violence Prevention (DVP) staff of SDOH in research, practice, surveillance, policy, and communication activities. Over the past 5 years, the RVW has hosted trainings for other interested staff, .

- Cultivating diversity inclusion is essential for NCIPC to serve the public. Other WGs within the Injury Center, such as the Tribal Workgroup and Drug Overdose Health Equity Workgroup, are focused on tying diversity issues into NCIPC's work.

- NCIPC also supports CDC-Wide Workgroups. For instance, many Injury Center staff are members of workgroups focused on Blacks in Government, Disability, Latino/Hispanic Health, and Sexual and Gender Minorities. One NCIPC staff member is the current President of Blacks in Government and Dr. Houry will be representing the Injury Center on CDC's new agency-wide Diversity Committee, with Angela Banks serving as the alternate with her. The first meeting will be at the end of August.

Dr. Houry recognized that the Injury Center has been engaged in efforts led by the agency to prevent injury and violence through a health equity lens over the years. For example, the CDC OMHHE released the *CDC Health Disparities & Inequalities Report (CHDIR), 2011*. In that report, NCIPC highlighted its research related to motor vehicle injuries, suicides, homicides, and drug-induced deaths. This information was updated in the 2013 *CHDIR* publication that led to an agency summit to discuss these issues with stakeholders. NCIPC also participated in the *Strategies for Reducing Health Disparities — Selected CDC-Sponsored Interventions, United States, 2014* publication in which the Injury Center's Tribal work and motor vehicle injury prevention programs were highlighted. In the 2016 update, *Strategies for Reducing Health Disparities: Selected CDC-Sponsored Interventions, United States, 2016*, the Injury Center had an article that spoke to its efforts in preventing violence among high-risk youth in communities with economic policy and structural strategies.

In addition, many of NCIPC's existing projects have been addressing racial and health inequities over the years. To provide a few examples, Colorado's is adopting an anti-oppression framework for its Rape Prevention Education Program (RPE). The Rhode Island Coalition Against Domestic Violence (RICADV) staff, through the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program, have had several conversations with the Rhode Island Working Families Party (WFP) focusing on racial and health equity approaches to raise policy efforts and processes for convening community members. The Louisville Youth Violence Prevention Research Center (YVPRC) developed a community-level campaign using maps and social media to change the norms of violence among youth in an economically disadvantaged, urban, primarily Black community in Louisville. In all 50 states for the past 6 years, the Essentials for Childhood Indicators Project has been collecting indicators that map across the World Health Organization (WHO) SDOH Framework, which includes policies, racial discrimination, and poverty.

Touching on some of NCIPC's newer efforts among Divisions and Offices, the Office of Communication is developing a communication plan for addressing workplace diversity and racial inequities. This also will include a language matters tip sheet to help writers choose inclusive language. The Extramural Research Project Office (ERPO) is reviewing existing funding announcements around addressing health equity and/or disparities in violence prevention work. The Division of Overdose Prevention (DOP) is standing up Division, Office, and Branch retreats to discuss diversity within these units and how it impacts style and can contribute to building highly functional units. The Division of Injury Prevention's (DIV's) new suicide funding announcement focuses on comprehensive suicide prevention with an emphasis on vulnerable populations. The Division of Violence Prevention (DVP) recently approved 2 projects that address racism as a social determinant of violence. Given recent events, NCIPC extended its year-end funding deadlines to allow Offices and Divisions to consider focusing on health and racial inequities in their proposals. The Injury Center prioritized these projects and approved the following, which NCIPC looks forward to the prospect of funding and seeing get underway:

- ❑ Focusing on Racism and Structural Inequalities to Prevent Violence
- ❑ Qualitative Inquiry into Race and Violence through VACS
- ❑ Increasing the Pipeline for Minority Researchers in Injury and Violence Prevention
- ❑ Training and Education for Public Safety to Reduce Overdose Among Communities of Color
- ❑ National Violent Death Reporting System (NVDRS) Roundtable Discussions with Law Enforcement
- ❑ Shifting Structural Racism through Bystander Actions
- ❑ Evaluating Diversion and Decriminalization Policies for Primary Prevention of Violence

As the Injury Center continues to grow in areas of focus, it is important that NCIPC demonstrates a commitment to action and moving quickly. It also is important to ensure that NCIPC's commitment is not a one-time checkbox and that the Injury Center is making sustainable change. There is much more work to be done to address systematic and institutional barriers. NCIPC's work will continue to evolve as they grow and learn. The Injury Center will continue to be transparent in keeping the BSC up to date on its efforts, is always interested in the BSC's feedback, and greatly appreciates the BSC raising this as a topic for which to allocate dedicated time.

Health Equity, Violence, and Racism

Overview

Thomas Simon, PhD
Associate Director for Science
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Simon indicated that he was presenting on behalf of Dr. Mercy who was unable to attend due to a family emergency. He provided Dr. Simon with his presentation and expressed his regrets for having to miss this opportunity, because he really wanted to emphasize that understanding and addressing racism is essential for preventing violence. Just like violence cannot be prevented without addressing sexism and economic disadvantage, violence cannot be prevented without addressing racism. In part, public health is about social justice. As such, CDC must address racism in all that it does in terms of hiring, research, surveillance, programs, supervision, and daily interaction. DVP staff recognize that they have not done enough and need to do more and are wrestling with how to do this in their work and in their working relationships with each other. DVP is fortunate because staff are committed to anti-racism and moving the Division forward on this issue and because DVP has a WG specifically dedicated to addressing issues pertaining to race and violence.

DVP has a long history of focusing on Black and Hispanic populations in its work. For example, when Dr. Mercy first arrived at CDC in the early 1980s, his very first investigation was of 20 chokehold-related deaths at the hands of police officers in Los Angeles. Unsurprisingly, these deaths primarily involved Black victims. Dr. Mercy and his colleagues described how those with underlying health conditions like sickle cell traits and heart disease were at increased risk for death when choked. In the early 1990s when CDC received its first Congressional appropriation for violence prevention, those funds were focused on supporting rigorous evaluations of youth violence (YV) prevention strategies with 15 sites throughout the country. Nearly 32,000 children and youth ranging in age from 5 to 19 years participated in these evaluations. These youth were predominantly Black and Hispanic followed by White, Native American, and Asian American.

In more recent years, the YVPRCs have had a consistent focus on preventing violence in high-risk minority populations. Dating Matters, a multi-faceted teen dating violence (TDV) prevention program developed by DVP, was piloted across 4 urban populations with high rates of crime and economic disadvantage. Since around 2000, DVP also has been increasingly focused on SDOH. DVP is proud that they are ahead of most parts of CDC in integrating attention to SDOH in its work. An example of this is reflected in DVP's efforts to translate and apply existing knowledge about SDOH and their relation to violence into programmatic funding. Using its

technical packages as a foundation, DVP has structured its programmatic Notice of Funding Opportunity (NOFO) to implement the best available evidence for prevention of child abuse and neglect (CAN), sexual violence (SV), YV, and intimate partner violence (IPV). In order to enhance population impact, DVP has placed increasing emphasis on implementing strategies at the outer levels of the social ecology and on interventions that impact community and social determinants of violence.

Although there is a long way to go in terms of addressing SDOH, there remains one very large gap in understanding and addressing racism as a social determinant of violence. As presented in previous BSC briefings, DVP is now engaged in a concerted effort to address this gap. DVP is integrating attention to racism in forthcoming research funding announcements, assessing extramural funding announcements and hiring practices, and working internally to address the way racism impacts its working relationships. Dr. Simon indicated that during this meeting, the BSC would hear about 2 aspects of this work: 1) Dr. Rosalyn Lee and Ms. Candace Girod would describe the activities of the Race and Violence Workgroup with a focus on their efforts to assess DVP's research and programmatic NOFOs to determine how to improve and strengthen attention to racism and health equity issues; and 2) Dr. Mildred Williams-Johnson would discuss minority representation on NCIPC's review panels and ways that they may be able to attract and more fully engage minority researchers and minority-serving institutions in the Injury Center's extramural funding.

Race and Violence Workgroup: Efforts to Help the Division of Violence Prevention Engage in Work to Eliminate Racial/Ethnic Inequities in Risk for Violence

Rosalyn Lee, PhD and Candace Girod, MPH
RVW Co-Chair and RVW Member, Respectively
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Lee and **Ms. Girod** presented an update on the activities of the RVW. The RVW is comprised primarily of DVP staff from the Research, Surveillance, and Program Branches; the Communications Team; and the Policy and Partnership Office. They also collaborate with fellows and staff from other parts of the Injury Center such as ERPO, the Injury Center's Associate Director for Science (ADS), and the DOP's Health Equity WG.

In terms of background, the RVW grew out of DVP's response to the June 2015 massacre by a young white male of 9 African Americans at the Historic Emanuel African Methodist Episcopal (AME) Church in Charleston, South Carolina. The Division Director asked a group of staff to consider what DVP's role should be in addressing incidents of race-based violence against African Americans. Staff raised the need to center considerations on better defining the role of DVP in addressing all inequities in risk for violence that African Americans and other racial/ethnic minorities face. While acknowledging other aspects of inequity and how they often intersect, the initial focus of the RVW was to address how the socially constructed concept of race and racism drive the creation and maintenance of inequities among the most highly burdened populations—Black and Brown people.

In 2016, the WG was formally established with the support of the DVPs Office of the Director (OD). They began engaging the staff and leadership in health equity/social justice workshops facilitated by the Michigan Public Health Institute (MPHI). In 2017, the RVW shifted its focus to include activities that would help DVP develop a strategic plan and build the capacity to eliminate racial/ethnic inequities. As a first step, the RVW conducted an assessment of DVP's written products published in 2016. They found that although communities of color have an increased risk for violence, DVP-written products largely did not focus on these populations and often did not discuss racial/ethnic group differences. Also, when race was mentioned or group differences were presented, the information was rarely contextualized. In other words, information about race or racial/ethnic differences was rarely linked to racism and underlying structural factors that create the conditions for inequities. The RVW shared the findings of the publication review during a DVP-wide meeting in October 2017 and then began developing a strategic plan to guide next steps.

Dr. Lee, Ms. Girod, and several others (Allison Ertl, Molly Kurnit, Rachell Leavitt, Marilyn Metzler, Khiya Mullins, Emiko Petrosky, and Kamerson Sheats) developed a summary report of the DVP-wide meeting and a strategic plan for moving forward. They incorporated feedback and ideas from the DVP-wide and other ad hoc meetings with staff into the plan, and then had a dialogue with leadership regarding recommendations in March 2019. The plan recommendations are framed around 3 pillars: 1) building staff capacity to engage in the work of health equity; 2) fostering dialogue around the importance of engaging in the work' and 3) establishing supportive policies to institutionalize the shift in what they do and how they do it.

Engaging in dialogue with leadership, they have begun to implement several of the planned recommendations. The most visible initiative has been co-hosting Express Lunch with the DVP Director. These events began unofficially in response to racial violence in Charlottesville, Virginia in August 2017. The RVW was committed to not letting the first gathering become a one-off activity or one that was disconnected from the DVP's work. Express Lunch was folded into the strategic plan. These events provide space for staff to personally deal with current events and a forum to discuss how they could or should integrate related issues into DVP's work. Since 2017, additional Express Lunch events have been held to acknowledge racial and ethnic violence against the Latino community in El Paso, Texas; to acknowledge the #LivingWhileBlack social media campaign, which highlights how microaggressions against African American of all ages can lead to lethal violence; and most recently, to acknowledge police abuse and violence against Black and Brown people.

Additionally, a subset of the RVW is updating a training that will be conducted in 3 parts for each Branch and Office. The training will consist of an overview of the World Health Organization's (WHO's) *A Conceptual Framework for Action on the Social Determinants of Health* with applications from existing work in DVP. In addition to building staff capacity to use a framework designed to unmask and address health inequities, an added benefit of the training is that it serves as a mechanism for leadership development for the trainers who are also DVP staff. The RVW. The RVW also has been working with the ADS at the Division and Center levels to encourage integration of health equity into the concept development and clearance processes in DVP's work products. The clearance checklist and approval process system now include reminders for supervisors and staff that hopefully will encourage inclusion of health equity in projects. The RVW hopes to assess how well the systems are working and if necessary, will work with the ADS to make sure the systems are effective. The RVW also has begun to work with the DVP ADS on a guidance document on contextualizing racial/ethnic differences in written products. In addition, the RVW has engaged in conversations with leadership about

integrating health equity criteria into performance appraisals so that staff will understand that they all can contribute to the work of health equity.

During the December 2019 BSC meeting, BSC members indicated interest in seeing an assessment focused on funding similar to the RVW's publication review. Conducting such an assessment was a priority of the RVW, so they immediately followed up after that meeting to begin planning for the conduct of a NOFO assessment. BSC members also recommended that the RVW move beyond the internal review of publications and conduct a broader systematic review of the literature. The RVW followed up on that recommendation as well. Dr. Lee shared some of the progress being made on this work. In 2017, in developing the plan for understanding DVP's commitment to addressing racial inequities, the RVW developed a list of possible indicators that included data surveillance systems, partners, social media, and translation tools. They chose to begin by assessing DVP's publications because they tend to have a broad reach and communicate to the public the ideas and priorities of DVP. They are now moving to look at funding through cooperative agreements, grants, and contracts because those reflect the work to which DVP is most committed.

There are two parts to this review. First, the RVW wants to understand what DVP asks applicants to do. To assess this, they looked at NOFOs. They also wanted to know what applicants say they are going do based on what is asked of them. Currently, there are 12 NOFOs and 37 awards for research and 12 NOFOs within the awards for programmatic efforts. The RVW developed research parameters by mapping out the parts of the NOFO and applications. They wanted to understand how the violence topic is characterized regarding racism, as well as the relationships to study populations. They also wanted to know how equity is treated in terms of whether there is attention to difference in risk as well as differential burden. They are using an iterative approach to develop coding manuals for the NOFOs and awards because they want to ensure that the questions they are asking actually get at the information they want to know. To ensure reliability, they will spend extensive time reviewing the coding manuals with their 14-person team of reviewers, ensuring that all reviewers understand the intent of each coding question. NOFOs and applications are being reviewed in pairs, with each person reviewing separately and then comparing codes to ensure validity. They invited the Health Equity Workgroup from DOP to develop the manual with them, and they are implementing a similar process for their NOFOs as well. This project is in the piloting stage and the BSC's feedback on the elements currently coded for would be beneficial.

To examine priorities for funding, the RVW decided to pay attention to a few separate domains that include: Violence Topic Areas, Population, Partnerships with Community-Based Organizations (CBOs), Socioecological Model (SEM) Level Addressed, and WHO SDOH Framework Domains Addressed. For both research and programmatic awards, the RVW is looking to understand what types of equity are addressed and whether inequities are contextualized in terms of the underlying reasons for why they exist. For the research awards, they want to know specifically whether the Principal Investigators (PIs) write equity-based research that supports any stated interest in working with populations at increased risk. When applicable, they want to understand whether their analysis plans include methods that will allow them to highlight inequities if they exist. For instance, does the analysis plan look for within group differences and differences between groups? They also code whether projects include plans to share the research findings with the study populations, as well as other populations at high risk. For programmatic awards, they want to understand whether applicants discuss equity, differential burden, et cetera as motivating factors for the population of focus, choice of programs, methods for implementation, and/or evaluation. They see this serving as a baseline for future reviews that will measure projects over time.

As they gain a fuller understanding of DVP's violence prevention efforts, as recommended by several members of the BSC in December, it also is important to understand where the large field is with respect to exploring links between racism and violence. They have obtained support from DVP to conduct a machine learning (ML) systematic review of the literature with the assistance of a contractor. ML and natural language processing (NLP) are programming techniques that can be used to facilitate scanning of the literature. It is a method that uses computer modeling to review and retrieve relevant articles, expanding the scope of what can be accomplished by reducing the level of effort required. Most systematic reviews end with a paper. However, the RVW would like one of the end products of this review to be a dashboard that can be used to help DVP staff address critical gaps in knowledge, track trends related to racial and ethnic inequities, identify social determinants that drive elevated risk, and identify effective interventions and policies to eliminate racial and ethnic inequities. They want to identify the types of racism, as well as the types of violence explored in the literature. They are at the beginning stages of refining the parameters of the review. While the primary focus of the review will be structural racism, institutional and interpersonal forms of racism will be included as well.

DVP has a traditional set of violence topics areas that include CAN, SV, IPV, YV, suicide, and ACEs. However, consideration will be given to including community-level violence, police abuse, and other violence outcomes that disproportionately impact communities of color. During the discussion period of this meeting, the RVW will seek feedback from the BSC to help shape this project. The next steps for the NOFO assessment are to revise the review based on BSC comments; complete the review pilot; conduct the coding for NOFOs and awards; conduct the analysis; discuss the results and implications for NOFO language with DVP leadership, ERPO, and the RVW; and share the results with the BSC in December 2020. Ultimately, the goal is to use the results to inform modifications to the way in which NOFOs are written. The next steps for the systematic review are to solidify the parameters of systematic review; with assistance of a contractor, use ML methods to identify relevant articles; complete the review by September 2021; and discuss the results and implications for DVP's research agenda, funding announcements, and research and programmatic technical assistance (TA).

There is a small but growing group of staff who have dedicated countless hours to conceive of and implement these initiatives. The projects shared today are the result of efforts of the Strategic Plan Subgroup, NOFO Assessment Subgroup, WHO Training Subgroup, Express Lunch Planning Subgroup, and the Systematic Review Core Team. Many of these subgroups are comprised of a crosscutting group of staff from the Research, Surveillance, and Program Branches; the Communications Team; and the Policy and Partnership Office. Also, in an effort to facilitate replication of these efforts across the Injury Center, an invitation was extended to colleagues from the DOP. The DOP participated in the development of the NOFO assessment, coding manual, and reviewer training. Members of senior leadership at the Division and Center levels are acknowledged as well for welcoming these efforts and working with the RVW to implement these initiatives.

NCIPC Extramural Research Report on Minority Representation

Mildred Williams-Johnson, PhD
Director, Extramural Research Program Operations
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Williams-Johnson presented responses to specific questions the BSC raised regarding the presentation of ERPO updates during the December 2019 NCIPC BSC meeting. At that time, she provided a report on the extramural research funding to date. In the comments regarding that report, the BSC specifically raised questions pertaining to representation of minority researchers and institutions in the funded research portfolio for the NCIPC and the extent to which the processes of considering applications for extramural research program funding include minority representation. The specific questions included the following:

- What is the minority representation in the peer review process?
- What is the minority representation among applicants for NCIPC research funding?
- How many minority institutions or investigators have received NCIPC research funding?
- What steps is NCIPC taking to increase minority representation in its research funding?

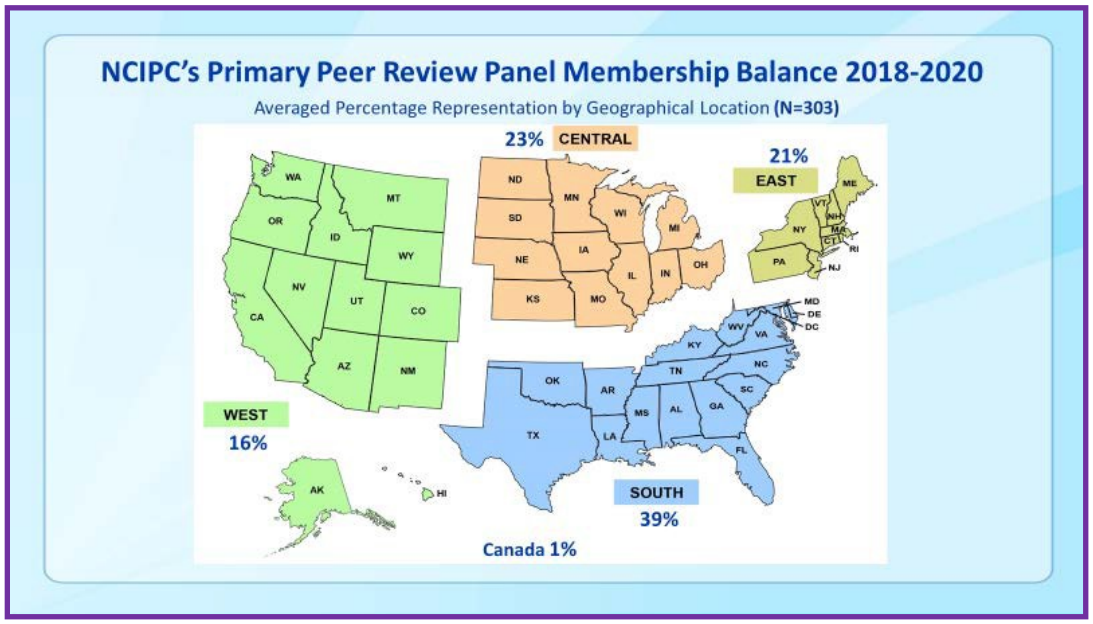
In response to the first question from the BSC regarding the minority representation in NCIPC's primary peer review, Dr. Williams-Johnson first provided some context for how the Special Emphasis Panels (SEPs) for Primary Peer Review are established. Primary Peer Review is conducted under CDC's Disease, Disability, and Injury Prevention and Control SEP charter according to FACA. This is a specific committee that is managed by the Strategic Business Initiative (SBI) Unit to ensure that all Primary Peer Reviews across CDC adhere to the requirements in the charter.

In accordance with FACA requirements, members of a FACA-chartered committee must be balanced to reflect the population of the United States (US). How that membership balance is achieved is determined by the CDC and other agencies that follow FACA requirements. CDC adheres to HHS policy and General Administration Manual (GAM) regulations governing panel membership. That includes assessing the specific expertise of potential panel areas in the program areas that are necessary to critique applications as a part of the objective review process. In addition, they must meet GAM requirements for gender representation; minority representation; public/private institution or governmental representation at the state, local, or federal level; and geographic representation across the US.

The following table reflects NCIPC's Primary Peer Review Panel membership balance for the years 2018-2020 (N=303) in terms of affiliation, representation, and balance. This represents all 20+ panels for all program areas. While representation in the table reflects an average across all of these panels, it is important to note that this representation must be reflected individually on each of the panels:

Representation	Category	Average (%)	Range(%)
Gender	Male	40	---
	Female	60	---
Minority		26	**(25-27)**
	Asian / Pacific Islander	8	(5-9)
	Black / African American	9	(8-10)
	Hispanic	5	(4-7)
	Native American	3	(2-5)
	Other	1	---
Public / Private Affiliation	Public / Private	38	(32-48)
Governmental Affiliation	State / Local Government	58	(46-66)
	Federal Government	3	(2-6)

First and foremost in selecting peer review members for the panel is selecting individuals with the scientific expertise necessary to critique the applications submitted and being considered for funding. Among those scientists who agree to serve on the panel, there much be balance among the members. Over the last 3 years, the average for gender representation has been 40% males and 60% females. Minority representation has been 26% with a range of 25% to 27%. Minority representation is broken down in the table by the minority categories designated by the SBI Unit. It is important to note that the peer reviewers who serve on the panel identify their own race and ethnic representation. This is not determined by the CDC. Representation from the public and private sector averages 38%, state and local government 58%, and federal government 3%. Geographic distribution is depicted by the following map:



Dr. Williams-Johnson emphasized that it is not possible to determine the minority status of the PIs in terms of their ethnic or racial identification. They can determine whether an applicant is from a Minority Serving Institution (MSI). It also is important to note that the designation of a MSI from the Department of Education may be grounded in a statutory definition or different programs for which institutions may have representation of a certain percentage of minorities who they serve. However, any given agency has the ability to define what it considers to be a MSI depending upon its program interests. CDC also looks for those institutions considered to be Hispanic Serving Institutions (HSIs), HBCUs, and Tribal Colleges and Universities (TCUs) as defined by the Department of Education. Minority representation among applicants and recipients for NCIPC research funding for the years 2012-2020 is shown in the following table:

Minority Representation Among Applicants and Recipients for NCIPC Research Funding
Preliminary Data for NCIPC Research Grants: 2012-2020

Grant Type Program Topic Area	Number of Applications	Number of MSI Applicants	Number of Funded Applications	MSIs Funded
R49 ICRCs	25	0	9	0
R01 Violence Prevention	259	5	19	0
R01 Overdose Prevention	100	1	20	0
TOTALS	**384**	**6**	**48**	**0**

This assessment considered the Injury Control Research Centers (ICRCs), violence prevention, and overdose prevention awards. A total of 384 applications were received across these 3 programs, of which 6 were submitted from MSIs. Among the applications received, no MSIs were funded during the assessment timeframe. This is important in that it informed the work NCIPC is doing to increase the number of applicants from MSIs and the competitiveness of those applicants. The current NOFO language for full and open competition reads as follows:

> Section III. Eligibility Information – "The following types of Higher Education Institutions are always encouraged to apply for CDC support as Public or Private Institutions of Higher Education: Hispanic-serving Institutions, Historically Black Colleges and Universities (HBCUs), Tribally Controlled Colleges and Universities (TCCUs), Alaska Native and Native Hawaiian Serving Institutions…."

There are efforts more generally in terms of an ongoing standing program announcement, FOA PA-20-222, by the National Institutes of Health (NIH) and CDC's National Institute for Occupational Safety and Health (NIOSH) that is designed to provide supplemental funding to an existing award to support efforts that enhance diversity of the research workforce through recruitment and support for students, post-Doctorates, and eligible investigators from diverse backgrounds and groups under-represented in agency research. The challenge with this particular program is that it is a supplement to already-funded recipients. Therefore, it does not necessarily provide the best possible avenue for increasing minority representation in NCIPC's

funding. However, this may be a program area to consider moving forward. This announcement has been published and will be open to applicants in June 2023.

In terms of other steps proposed for BSC's feedback and consideration to increase minority representation in NCIPC-funded research, the following potential language might be utilized for all future NOFOs:

Section V. Application Review Information, 4. Review and Selection Process

- ❑ Contribution to diversity in funded applicants and investigators conducting injury and violence prevention research.

Section I. Background and Purpose, 2. Approach, Collaborations and Partnerships

- ❑ Stated interest in collaborative research with minority investigators, especially those working in MSIs.
- ❑ Stated interest in research proposals with MSIs as partners.

As mentioned earlier by Dr. Houry, NCIPC received end-of-year funds to initiate a project for increasing the minority researcher workforce specifically for injury and violence prevention research. NCIPC has received applications for potential partners for implementation of this project and would be conducting a review over the next several days to identify the best proposals to help achieve the specific Minority Researcher Workforce Development Project goals to: 1) increase the number and competitiveness of underrepresented minorities investigators conducting injury and violence prevention research; and 2) increase the number and competitiveness of MSIs applying and receiving NCIPC Research Funding.

One of the planned program activities to achieve those goals is to develop a curriculum to increase awareness of NCIPC opportunities and increase the knowledge of the targeted population in terms of how to be more competitive with the applications they submit. That may include sharing with them how to understand and use the peer review criteria in developing their research plan and approach, develop partnerships with community partners who are engaged in research, use the information available on grants.gov and receive notifications when new research opportunities are forecasted, and navigate the application process. This is an automated process and sometimes, very small issues may stop an application from being received by CDC, such as not having a current investigator profile.

Other planned activities include piloting the curriculum; determining venues/forums for delivery and developing a plan for expansion; developing an evaluation plan to measure success; and assessing strategies to partner with MSIs for increased exposure to CDC extramural research processes and violence and injury prevention research. Additional activities NCIPC wants to consider bringing on board to increase the minority researcher workforce include increasing participation on peer review panels, increasing opportunities for faculty participation in CDC Guest Researcher program, and increasing student participation in CDC internships or fellowships. The proposed outcome measures NCIPC already has developed for the pilot project include: 1) 70% knowledge gain about NCIPC research priorities, funding opportunities, and programs by participants; and 2) 15% to 20% reported participant interest in applying for NCIPC research funding opportunities.

Dr. Williams-Johnson closed her presentation by posting the following questions for the BSC's consideration and discussion to assist NCIPC in moving forward with the program activities described, which Dr. Whitaker reviewed before facilitating the discussion with the BSC:

1. Are there other questions that should be included in the NOFO assessment to help ensure that funded projects intentionally focus efforts on closing gaps between racial/ethnic groups in violence outcomes?

2. Racism can be broadly defined to include multiple forms (e.g., structural, institutional, interpersonal). We may need to narrow the parameters for the systematic review. What parameters do you think are essential?

3. What is your feedback on language proposed for the NOFOs?

   - ❑ Review and Selection Process:
     - ➢ Contribution to diversity in funded applicants and investigators conducting injury and violence prevention research.

   - ❑ Collaborations and Partnerships:
     - ➢ Stated interest in collaborative research with minority investigators.
     - ➢ Stated interest in research proposals with MSIs as partners.

4. What additional language in the NOFOs would attract more interest and applications from minority principal investigators and MSIs?

5. What other activities could the NCIPC consider to increase minority PIs and MSIs in NCIPC-Funded Research?

Discussion Points

Dr. Kaplan noted that while there was continued discussion about racial and ethnic groups, absent from the discussion were the issues of social class and intersectionality of class and race as they related to violence prevention. He recalled that years ago he spoke on neighborhood gun violence in Chicago in 77 community areas. It continues to be found that the most deprived communities, those with 20% to 40% of all households living under the poverty level are the most prone to gun violence. With that in mind, he suggested that there needs to be more emphasis on socioeconomic issues in connection to race/ethnicity, with more language on social class.

Dr. Liller agreed with Dr. Kaplan. In terms of other questions that should go in NOFOs, perhaps his comments about social class and socioeconomics could inform items in the NOFO assessment regarding what is included with structural racism or systemic racism. If the NOFO could be narrowed somewhat to focus particularly on the idea of structural or systemic racism, it would most likely bring in some of the social class issues.

Dr. Barnes commended NCIPC for the efforts to try to minimize inequality. In terms of the second BSC discussion question posed, it seems like NCIPC is working on the structural and institutional issues. However, interpersonal seems to be missing. She asked NCIPC to provide their definition of interpersonal and how they think they can rectify that.

Ms. Girod asked whether Dr. Barnes was referring to how to address interpersonal racisms in workplaces, the NOFO project, or staffing.

Dr. Barnes pointed out that once someone applies and is accepted, they still have to deal with interpersonal racism. NCIPC can do everything in their power to put people of color in positions, but once they are there, they may not necessarily be given all of the respect that others are given only because of their color. She referred to an article shared by Dr. Chou by a Black scientist at Duke who mentioned that when one speaks out about inequality or racism, it is committing career suicide. Because speaking about racism and inequality makes people uncomfortable, it is difficult to deal with this in terms of interpersonal relationships. NCIPC can do everything possible to address/minimize institutional and structural racism, but they also must deal with interpersonal racism because attitude and behavior are two different things.

Dr. Houry said that the Injury Center has been examining its internal culture, which is why they are bringing in a consultant to qualitatively assess NCIPC's processes and dynamics to help determine where improvements can be made. They are trying to set an example for the rest of CDC and other Centers by addressing their own internal culture. Consideration has been given to other mechanisms such as training, but NCIPC prefers to have an outside consultant assess its internal culture first. They are trying to do this very thoughtfully and over time so that all staff are comfortable coming forward, all are welcomed, and there are no issues or unintended consequence. The goal is to use a lot of internal assessments to determine where the pockets are and how best to address them.

Dr. Schwebel observed that there appears to be a strong group of perhaps 15 to 20 HBCUs and MSIs that have the infrastructure for research and faculty who have time to conduct high quality research. He sees the HBCUs in Alabama where he is, Miles College in Birmingham and Stillman College in Tuscaloosa, as teaching institutions that serve an important role in that way. However, it is not clear that the faculty there have time to conduct the kind of research that NCIPC expects. They may have the skills but not the time. He requested that his colleagues who are at HBCUs and other MSIs to comment on that. Department of Transportation (DOT) University Transportation Centers (UTC) Program research centers require partnerships with MSIs. Perhaps this model could be assessed to determine its level of success.

Dr. Crawford said that when he hears comments such as, "we need to expand consideration of economic class," those things are so genuine. But once everything else is taken away, it is still necessary to deal with the race issue. His fear is that if they start looking at so many other aspects that are proxies to race, they are going to lose the flavor and focus of what this whole movement is about. When there are numerous people who are from different racial and ethnic groups, there are distinctions between those groups that need to be highlighted. Every group is not impacted in the same way by every aspect of institutional or structural racism. To get to the root of it, they must stick to those things specific to the group and then move to generalization. The BSC deals with things very cerebrally because that is who they are. However, when a group that he works with does that, they tend to naval gaze. The questions that they ask are those things that they know to ask and are within the limits of what they can ask and know about. He is particularly concerned about looking at the research funding from NCIPC and seeing no MSIs in the funded column and for that now to be on reactive basis. He would have thought that would have been a concern from the outset. The Injury Center should look at itself to determine why these types of statistics could exist for so long and why nobody raised an eyebrow, or if they did, why no one was able to do anything about it. What are the structural constraints to that? What are the constraints that may be working against this? Even though there are numerous initiatives going forward and perhaps some metrics to be able to measure it,

the reality is that until this point, this is still where they are. Unless they understand those aspects that led to this point, regression to the mean is real. The same practices, thoughts, collaborations, et cetera will continue to result in zeros in the MSI-funded column on an ongoing basis. He emphasized that he was not saying that to criticize the process. He thought it was wonderful. But he also knows the reality of all of the work NCIPC has to do, the priorities that they have to have, and the politics they have to deal with. In terms of exemplary practice, while they talk about best practices, to him "best" is quantitative. Where are the exemplary practices for the MSIs? Where are the exemplary practices for the HBCUs? When he looks around his own HBCU after having retired from Boston University School of Medicine (BUSM) for a number of years, he sees the differences in resources, the kind of connections that many of the faculty members have with students, and how so many people give so much more. BUSM had the resources there to be able to give as they did or to be able to help with that. HBCUs do not have these resources. While there may be individuals at HBCUs conducting research, there are no groups. Where are the Centers for Excellence (CoEs)? Where are the collaborations with the Predominantly White Institutions (PWIs) and the MSIs/HBCUs on the different aspects of research that could occur and the growth and development of students? The lay of the land is really not understood. While he wished he could wave his magic wand, he knows this is going to take a lot of work. They cannot just talk to themselves, intellectualize themselves, and use their heads for this. They must use every resource and mechanism that they can to make a difference, including reaching out to the institutions that are impacted to ask them what the barriers are and keeping that up front and present for the discussions up for consideration. Dr. Crawford emphasized that he said this from the heart and from love.

Dr. Whitaker indicated that he is faculty at Georgia State University (GSU), which is a majority minority institution. GSU seems to be of two minds right now. They have made incredible progress in terms of teaching, graduating rates, and eliminating racial and ethnic disparities in graduation rates. Conversely, over the past 10 years, they have tried to gear up to become a research institution and have made incredible strides there as well. On the research side, his perspective is that there are institutional barriers across academia. Community work is just not rewarded like some of the more basic science laboratory-based work. This creates disincentives for faculty coming up through the ranks to do this kind of work. Faculty try to do things that are rewarded, and that is what they are told to do. Thus, there are systemic problems within university systems generally. As universities become increasingly prominent in terms of research emphasis, those problems only multiply. They become more competitive and there is increasing pressure for grants and publications. The problem for CDC is not just finding and funding this work. The problem exists in the academies as well in terms of what is prioritized and rewarded.

Dr. Compton said that it had been delightful to listen to this very important and timely conversation. These are issues that the National Institute on Drug Abuse (NIDA) and the NIH more broadly are wrestling with this as well. He expressed appreciation for the opportunity to learn how the Injury Center and CDC more broadly are addressing these. When he thinks about the issues related to disparities and addictions, NIDA is particularly focused on criminal justice populations where the racial inequities and disparities have been notoriously difficult to address. They have a large-scale new criminal justice program, so he looks forward to building on the Injury Center's really good ideas and imbedding them within NIDA's efforts within criminal justice to get at the systematic bias and racism for persons with addiction in criminal justice settings in particular. He thinks NCIPC's explicit focus on racism and bias will have an application to health issues more broadly, particularly in terms of the addiction field. While the scientific workforce was not the main topic for discussion, he takes workforce issues very seriously and looks forward to hearing how NCIPC will address this in terms of new policies and

requirements for grantees . NIDA has made diversity an explicit requirement for its training grant, but he cannot say whether that has been successful because they still see the scientific workforce seriously under-represented by minority scientists. He looks forward to seeing whether NCIPC can have some success in this area and how NIDA might be able to build on that. The National Science Foundation (NSF) had done some very innovative Science, Technology, Engineering, and Math (STEM)-based outreach to HBCUs and other MSIs that might serve as a model as well. Related to internal racism and staffing issues, NIH has been focusing on training on implicit bias and there may be benefits from implementing this on a widespread basis. Dr. Compton will share them with the NCIPC BSC as those efforts develop and looks forward to hearing the ideas of others so that NIDA can do a better job of addressing the internal and external social inequities in their field.

Dr. Cunningham expressed appreciation for the conversation, including the discussion around institutions. What she has a problem with and does not understand is the lack of measurement of investigators' race and ethnicity status. NIH has published articles about the race and ethnicity of PIs. If CDC and NCIPC are not measuring that, it is not clear how they will ever change that or set goals for appropriate representation. She also was surprised to see the definition of "minority." It appeared to be different from the NIH definition, so she wondered whether "minority" meant under-represented minorities or had a different definition. The curriculum as one initiative is interesting, but this does not go far enough in general. A curriculum certainly is necessary, but it is not sufficient. The NOFOs do not go far enough either. Why not require multiple PIs, one of whom must be a minority? Why not require new initiatives that specifically focus on minority investigators. Every researcher she knows who has been successful has been the recipient of a minority-specific award. Dr. Cunningham personally was a recipient of an award like that through CDC, and that was a game-changer for her in her career. The Injury Center needs to have something like that. The bottom line is that the efforts are not going far enough, and more explicit initiatives are needed for minority investigators to lead efforts.

Dr. Whitaker inquired as to whether someone from the Injury Center could answer the question directly about why there are no data about race and ethnicity of investigators and about whether there is a mechanism for targeting particular individuals, such as was done during the human immunodeficiency virus (HIV) years.

Dr. Williams-Johnson said that they have discussed asking grant recipients to identify their race and ethnic representation after they are awarded. From program standpoint, they have no way of seeing how a recipient identifies their race and ethnicity in their NIH profile. That information is only available on the peer review side as it relates to individuals potentially serving on a panel to address some of the representation requirements. From the program side, they have to ask the question post-award, which is why they do not have those data. While they have never asked this question comprehensively to the award recipients in the NCIPC's portfolio, they can do so moving forward. She will have to ask the SBI Unit where the definition used for "minorities" came from and why it differs from the NIH definition. She said that everyone's points were well-taken in terms of some of the other initiatives that NCIPC might consider going forward.

Dr. Chou said he thought the systematic review was a good idea but thought it seemed incredibly broad. Asking whether there is racism is very different from what can be done about it and what is effective. He wondered whether there would be opportunities for the BSC to provide input or feedback once the questions and parameters are narrowed down. Because the review

is so broad, some prioritization may be important and perhaps the BSC can be helpful with that. Regarding the use of ML, his main area is systematic reviews. It may be overly optimistic for a topic like this. First of all, the machine must be trained and that requires a lot of upfront effort. Typically, it requires going through thousands of citations. The planned review is not straightforward like a drug review of a randomized controlled trial (RCT). It is a very messy area and it is not clear whether the MLs will be able to do that much in terms of accurately picking up things. The Agency for Healthcare Research and Quality (AHRQ) and some other groups have done quite a bit of work trying to figure out how to use MLs. They are helpful once trained for maintaining the reviews. Because this is such an important topic, perhaps this should not be a one-off review and should be maintained as a living review. In that situation, the MLs may be more helpful, because once they are trained up, they can help screen for future studies. However, they may not be that useful for the initial review.

Dr. Coffin indicated that NIDA funds multiple projects that focus on early career training in order to try to overcome some of the structural barriers that make it extremely difficult for people of color to get into and succeed in research. Those are very real barriers and it is somewhat of a long game, but it is a critical element for the Injury Center to consider in terms of increasing the pool of investigators of color in the long-term who can successfully compete for grants. Regarding anti-racism, which was raised in some of Dr. Frye's comments, he emphasized that in addition to hiring and retention, the impacts and constructs of anti-racisms should be studied in research. That is a very important and innovative element to consider.

In terms of the language in NOFOs, **Dr. Liller** indicated that at the University of South Florida (USF) is very intentionally addressing all of these issues in their curriculum, courses, et cetera. Publishing particular NOFOs for minority PIs and MSIs would be great. Perhaps the ICRC NOFO could include a requirement such as DOT has to partner with a MSI. We should think about it in terms of being much more intentional rather than just encouraging or having efforts that encourage participation. They have observed at USF that while they do have minority researchers, we have to be very careful in academia because what happens is that individuals who are minorities are placed on several committees and have to do much service because everyone wants minority representation. The danger of this is the faculty have no time then to dedicate to research, publications, and other efforts that are going to get them promoted, known in the field, and further their careers.
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Dr. Whitaker said that there is a much greater service and mentoring demand at GSU as well, which they want to do, but in some ways, it negatively impacts their grant writing and publication efforts. There is an accrual of disadvantage that can occur.

Dr. Schwebel agreed that specific NOFO language is a good idea but pointed out that it is somewhat symbolic. If it is buried on page 12, he had to be honest that as a PI, he might barely notice it or not even read it because he has administrative staff to read those things. While it is a good idea, he does not think it will have a major impact like some of the other efforts might.

Regarding other activities NCIPC could consider for increasing minority PIs and MSIs, **Dr. Hedlund** suggested making some NOFOs explicitly for minority PIs or MSIs.

Dr. Greenspan indicated that there are some challenges in limiting NOFOs to . minority PIs or MSIs. Current policies require full and open competition, they have to provide strong justifications or it may not get approved. She called on Mildred to comment further on that.

Dr. Williams-Johnson indicated that they would have to talk to the Office of General Council (OGC) and the Office of Grant Services (OGS) about the opportunity for CDC to do that and whether they have any statutory authority that would allow this. CDC has different authority than NIH has. The reviewer selection process is at the program level, which may place them in a position to have more impact than just "encouraging" because they could view that as a part of the decision-making process on funding. But they will have to further explore inclusion of more intentional language in NOFOs in terms of legal and grant policies.

Dr. Whitaker pointed out that the review process is the other place to address this. His experience with review processes is that what gets counted by reviewers are issues around internal validity pertaining to the methods, importance of research question, and other things. The things they were discussing tend to get discounted in review panels. He noted that a suggestion was written in the chat box to identifying reviewers who understand the importance of these issues to get them in the mindset that NCIPC wants weighted appropriately.

Dr. Habermann supported Dr. Hedlund's comments on deliberately funding minority PIs or MSIs. She recalled that in prior BSC meetings, there was discussion about grants focused on minority populations as well as an additional criterion.

Dr. Kaplan indicated that he has received notices from NIH quite often that have to do with the pre-application TA webinar that they offer. It is not a prerequisite to apply, but it is useful and there is a recorded version as well. He did not know whether the CDC does that, but perhaps they need to if not. He thinks there needs to be a lot more outreach because some researchers might see this process as too competitive and too time-consuming when they are focused almost exclusively on teaching and administrative responsibilities.

Dr. Maholmes echoed the comments colleagues made about overwhelming responsibilities that minority faculty and researchers have to teach, serve on committees, be mentors, and conduct their own research. It is often a burden and a double-edged sword. She has been encouraging her own institution, the National Institute of Child Health and Human Development (NICHD), to invest more in having protected time for mentoring. They have a mid-career career development award that would allow protected time for established faculty members to mentor early career investigators, particularly minority faculty members. This is very important because there is value in that it allows institutions that value mentoring time to get credit for that moving toward promotions and tenure. Her own experience was that it was burdensome to the extent that some of the available faculty members would not even entertain supporting an early career investigator's research because they simply did not have time. There are many faculty members at PWIs and Ivy League schools who are the only ones who are Black in their departments. Oftentimes they struggle to find someone to help them learn about the application process. They do not always get the information. There is a lot of discussion in the literature about the "imposter syndrome" that causes people not to ask for support to do research or other things that pre- or post-Docs and fellows do. There should be a concerted effort to ensure that those individuals who are not willing to ask for help are encouraged and supported by other faculty members.

Dr. Floyd recalled that a few weeks previously, there was a lot of publicity about internal claims from CDC employees regarding racism and treatment internally and a letter was sent to Dr. Redfield. He asked whether the information provided in that letter was informing anything that NCIPC is doing related to this work.

Dr. Houry responded that the slide that showed regarding the 7 actions CDC is taking was in large part a response to the letter Dr. Redfield has. Senior leaders across the agency have now had 4 meetings as a leadership team to assess how they can improve HR practices. That is where the funding for the HRO is. This also includes having unconscious bias training for senior leaders, and having Dean Williams serve as the Keynote Speaker for the Charles C. Shepard Science Award.

Dr. Porucznik said she has noticed at her institution, University of Utah, that the effects of shock such as the current pandemic are also not evenly distributed. For example, some of her graduate students are not returning to school even though their tuition is paid by scholarships because of other stressors that are occurring in their lives due to COVID-19. She wondered if another way to think about providing more support for under-represented populations could be in the realm of emergency funding or group support that is different from the typical R01 NOFO.

Regarding the inquiry about the BSC continuing to be involved with the systematic review, **Dr. Lee** said she thought the RVW would welcome that involvement. They realize that they are starting very broad and are working diligently to narrow down the parameters and welcome receipt of additional feedback.

Dr. Greenspan indicated that they could connect to Dr. Chou, who made that suggestion, with the RVW. She thanked all of the BSC members and ex officios for all of their comments. While they have not responded to every comment, they were capturing all of the comments in the Chat Box during the discussion period, and it has given them a lot to think about in terms of what they may be able to do moving forward and how they might expand some of their current activities.

Ms. Girod indicated that regarding the inquiry raised earlier about the intersection of social classes and race, there are questions in the NOFO review about socioeconomic status (SES), structural racism, institutional racism, and interpersonal racism.

Dr. Schwebel suggested that NCIPC consider mimicking to some extent the Research Experiences for Undergraduates (REU) program at NSF. These are summer research experience opportunities. He has used them in his laboratory from NIH and American Psychological Association (APA) grants. This allows them to bring undergraduates in to get research experience over the summer. He aims to get between 50% to 75% of under-represented minority students. Perhaps NCIPC could decide to make such a program exclusively minority-focused if regulations allow for this. This would capture under-represented students early in the pipeline and could get them focused on injury and violence research and get them excited about how research works. It is fairly low-cost, with 4 or 5 students brought in each year and paid about $5000 each. This has yielded over half of the students going on to Doctoral training programs.

Dr. Greenspan indicated that NICPC does have a lot of internship programs and is looking at increasing minority representation. There is a minority program and NCIPC has partnered with some of the local HBCUs to increase minority representation. She requested that emails be sent to her with the names of some of the programs so that they can consider ways of expanding minority representation among NCIPC interns and fellows.

Dr. Schwebel clarified that what he was suggesting was to supplement what NCIPC is doing to offer money to established research laboratories across the country in different regional areas. For instance, perhaps the Injury Center could offer a grant of $20,000 to universities in various regions to fund the recruitment of students to their university for the summer. He will email the information about NSF and APA.

Dr. Kaplan added to the conversation regarding training and early recruitment that the Bridges to the Baccalaureate Research Training Program (T34) from NIH have been quite effective. He was affiliated with one at his previous university and it worked remarkably well. Perhaps something like that could be developed at CDC apart from the internships that are offered. While those are great, something closer to the T34 might be quite helpful in the future.

Dr. Williams-Johnson indicated that they would take this back to the OGS, but that her understanding is that CDC does not have the authority for training programs as such. They would have to revisit this to determine whether anything has changed that would now permit this.

Dr. Maholmes asked to what extent NCIPC could partner with other agencies to co-fund training.

Dr. Greenspan emphasized that they are always interested in being creative in terms of figuring out how to make things work. She is happy to continue these conversations. She pointed out that while they focused this particular conversation on violence, they also have a recently established workgroup that is focused on drug overdose that is considering some of the same issues. NCIPC recognizes that these issues are not exclusive to violence, so they are broadening their reach in other injury topic areas.

Dr. Whitaker asked whether there are any cross-CDC groups working on this issue. One problem is that the agency is organized by dependent variables or outcomes, and this is a really strong independent variable.

Dr. Greenspan stressed that even though they are organized by topic areas, there is a lot of cross-collaboration and the Office of the Director tries to help facilitate some of that cross-collaboration as well. It may not be obvious based on the infrastructure of CDC, but it does occur. There also is a science group that includes all of the ADS in each of CDC's Centers. A subgroup of that group is looking at issues of disparities and health equity across the agency.

Dr. Williams-Johnson added that in terms of the projects described, the OMHHE has been engaged to provide guidance and important feedback to NCIPC.

Dr. Porucznik said she thought it was great that there are so many experienced leaders within the Injury Center who really understand how the system is presently working such as Drs. Greenspan, Williams-Johnson, and Cattledge.

Chat Box comments are posted in Attachment C.

Public Comment Session

Victor Cabada, MPH
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Mr. Cabada thanked everyone for their participation in the BSC meeting and indicated that all public comments would be included in the record and would be posted on the BSC website with the official meeting minutes. He also indicated that they would not address questions during this session, but any questions posed by members of the public would be considered by the BSC and CDC in the same manner as all other comments and that all written comments would be posted on the BSC website with the finalized meeting minutes. No public comments were provided during this session.

Closing Comments / Adjournment

Dr. Greenspan indicated that the following members would be rotating off of the BSC: Dr. Donna Barnes, Dr. Phillip Coffin, Dr. Kermit Crawford, Dr. Victoria Frye, Dr. James Hedlund, Dr. Todd Herrenkohl, Dr. David Schwebel, and Dr. Daniel Whitaker. She emphasized what a pleasure it had been to work with them. They have challenged NCIPC, brought to their attention additional issues, and recommended this particular session. She offered a special shout out to Drs. Frye and Whitaker who have served as Co-Chairs. She pointed out that this is usually done in person, but since this was not possible, they were sending virtual cake, a heartfelt thank you, and certificates would be mailed. She thanked them all for their contributions and their service to CDC, NCIPC, and HHS. She emphasized that while they were saying goodbye to some of the board members, they have their contact information and would love to continue to engage them on review panels and for consultations.

Dr. Whitaker said it had been an honor and pleasure to do this and to get to know the other members of the BSC.

Dr. Hedlund said it had been an honor to serve on this BSC and to deal with subject about which he knew virtually nothing. His role on this board has been to say “motor vehicle injury” about 3 times per meeting, and he expressed his hope that they would have someone who would continue to say that. He noted that in the welcome slide, 3 of the 5 pictures deal with motor vehicle injury. While this is not a big deal with everything going on these days, it still kills 35,000 people a year, so he requested that they keep it in the agenda.

Dr. Greenspan noted that she has done research on motor vehicle injury, so it is close to her heart as well and they will continue to have representation with expertise in that area on the BSC.

Dr. Coffin said it had really been a pleasure and honor working with and getting to know everyone. His focus has been opioids and he stressed that the Injury Center has done impressive and remarkable work and developed increasingly sophisticated understanding of the topic. He expressed his gratitude for that and the experience.

Dr. Greenspan reminded BSC members and *ex officios* to send an email to confirm their presence to ncipcbsc@cdc.gov. She expressed her appreciation for everyone’s participation in the meeting.

With no announcements made, further business raised, or questions/comments posed, **Dr. Whitaker** thanked everyone for their attendance and participation and officially adjourned the Thirty-Fourth meeting of the NCIPC BSC at 1:00 PM.

I hereby certify that to the best of my knowledge, the foregoing minutes of the August 20, 2020 NCIPC BSC meeting are accurate and complete:

10/13/2020
Date

Daniel J. Whitaker, PhD
Co-Chairperson, NCIPC BSC

10/10/2020
Date

Victoria Frye, DrPh, MPH
Co-Chairperson, NCIPC BSC

Attachment A: Meeting Attendance

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

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

Kermit Crawford, Ph.D
Associate Professor in Psychiatry
Department of Psychiatry Psychology
School of Medicine
Boston University

Chinazo Cunningham, M.D., M.S.
Division of General Internal Medicine
Albert Einstein College of Medicine
Montefiore Medical Center

Frank Floyd, M.D., F.A.C.P.
Medical Director
United Health Service Medical Group

Frank A. Franklin, II, Ph.D., J.D., M.P.H.
Principal Epidemiologist and Director
Community Epidemiology Services
Multnomah County Health Department

Victoria Frye, Ph.D.
Associate Medical Professor
School of Medicine
City University of New York

Elizabeth Habermann, Ph.D
Professor
Department of Health Services Research
Mayo Clinic College of Medicine and Science

James Hedlund, Ph.D.
Principal
Highway Safety North

Todd Herrenkohl, Ph.D.
Professor and Co-Director 3DL Partnership
School of Social Work
University of Washington

Mark S. Kaplan, Dr.P.H.
Professor of Social Welfare
Department of Social Welfare
Luskin School of Public Affairs

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

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

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

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

Ex-Officio

Melissa Brodowski, Ph.D., M.S.W., M.P.H.
Senior Policy Analyst
Administration for Children and Families

Mindy Chai, J.D., Ph.D.
Health Science Policy Analyst
Science Policy and Evaluation Branch
National Institutes of Health
National Institute of Mental Health

Wilson Compton, M.D., M.P.H.
Deputy Director
National Institute on Drug Abuse
National Institutes of Health

Holly Hedegaard, M.D., M.S.P.H.
Senior Service Fellow
National Center for Health Statistics
Centers for Disease Control and Prevention

Lyndon Joseph, Ph.D.
Health Scientist Administrator
National Institute on Aging
National Institutes of Health

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

Constantinos Miskis, J.D.
Bi-Regional Administrator
Administration on Community Living,
Administration on Aging

RADM Kelly Taylor, M.P.H.
Director, Environmental Health and Injury Prevention
Indian Health Service

Captain Josefine Haynes-Battle, MSV, BSN, RN
CAPT, United State Public Health Service
Director, SAMHSA/CSAP/Division of System Development

CDC Attendees

Victor Cabada, M.P.H.
Gwendolyn Cattledge, Ph.D.,MSEH, FACE, CHM
Casey Chosewood, Ph.D.
Melvin Crum, Ph.D.
Linda Dahlberg, Ph.D.
Rosalyn Lee, Ph.D.
Deborah Dowell, M.D., M.P.H.
Arlene Greenspan, Dr.P.H., M.P.H.
Debra Houry, M.D., M.P.H
Chris Jones, Ph.D.
Tonia Lindley
Amy Peeples, M.P.H.
Tom Simon, Ph.D.
Mildred Williams-Johnson, Ph.D., D.A.B.T.

Public Attendees
Carl Beck
On- Par Productions

Natalie Green
On-Par Productions

Antwan Jones
On-Par Productions

Attachment B: Acronyms Used in this Document

Acronym	Expansion
ACEs	Adverse Childhood Experiences
ADS	Associate Director for Science
AHRQ	Agency for Healthcare Research and Quality
AME	African Methodist Episcopal
APA	American Psychological Association
BSC	Board of Scientific Counselors
BUSM	Boston University School of Medicine
CAN	Child Abuse and Neglect
CBO	Community-Based Organization
CCTI	Cambridge Communications and Training Institute
CDC	Centers for Disease Control and Prevention
CHDIR	*CDC Health Disparities & Inequalities Report*
CIO	Centers, Institutes, and Offices
COD	Committee on Diversity
CoEs	Centers for Excellence
COI	Conflict of Interest
DELTA	Domestic Violence Prevention Enhancement and Leadership Through Alliances
DFO	Designated Federal Official
DIP	Division of Injury Prevention
DOP	Division of Overdose Prevention
DOT	Department of Transportation
DVP	Division of Violence Prevention
EAP	Employee Assistance Program
ERPO	Extramural Research Project Office
ET	Eastern Time
FACA	Federal Advisory Committee Act
GAM	General Administration Manual
GSU	Georgia State University
HBCUs	Historically Black Colleges and Universities
HHS	(Department) Health and Human Services
HRO	Human Resources Office
HSI	Hispanic Serving Institution
ICRC	Injury Control Research Center
IPV	Intimate Partner Violence
ML	Machine Learning
MSI	Minority Serving Institution
NICHD	National Institute of Child Health and Human Development
NCIPC	National Center for Injury Prevention and Control
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NLP	Natural Language Processing
NOFO	Notice of Funding Opportunity
NVDRS	National Violent Death Reporting System
OGC	Office of General Council
OGS	Office of Grant Services

Acronym	Expansion
OMHHE	Office of Minority Health and Health Equity
PI	Principal Investigator
PWIs	Predominantly White Institutions
RCT	Randomized Clinical Trials
REU	Research Experiences for Undergraduates
RICADV	Rhode Island Coalition Against Domestic Violence
RPE	Rape Prevention Education Program
RVW	Race and Violence Workgroup
SBI	Strategic Business Initiative Unit
SDOH	Social Determinants of Health
SEM	Socioecological Model
SEP	Special Emphasis Panel
SES	Socioeconomic Status
SOP	Standing Operating Procedure
SV	Sexual Violence
TA	Technical Assistance
TCUs	Tribal Colleges and Universities
TCCUs	Tribally Controlled Colleges and Universities
TDV	Teen Dating Violence
US	United States
UTC	University Transportation Centers
WFP	Rhode Island Working Families Party
WG	Workgroup
WHO	World Health Organization
YV	Youth Violence
YVPRC	Youth Violence Prevention Research Center

Attachment C: Chat Box Comments

Victoria Frye: Good morning and thank you again for engaging in this meeting.

Victoria Frye: I wish there were “clapping hands” or “thumbs up” here that I could click.

Victoria Frye: I have to leave now. I am pasting some thoughts here in groups.

Victoria Frye: Thank you for these detailed presentations. It is heartening to see the excellent work that is being conducted. I sincerely appreciate the attention to the BSC’s previous questions and suggestions.

Victoria Frye:
Consider for Research:

- Specific NOFOs requiring mPIship of underrepresented scientists, with an emphasis on African-American women. This was done in the past in HIV; why can it not be done now?
- Requirements that Injury Centers partner with MSI/HBCU with 50/50 effort and $$ split. specific funding on structural violence that results in racial disparities, such as maternal mortality disparities
- Specific research on police brutality and policy change impacts on outcomes; research on defund the police efforts, etc.
- Call for research on the impact of hate groups and white supremacist groups and rallies (e.g. Unite the Right @Charlottesville 2017) on health outcomes; impact of counter protests (Unite the Left @Boston 2017) on public opinion and violence incidence?
- Research on impact of media coverage of hate groups and white supremacist groups and rallies on engagement in various forms of violence.
- Focus opioid funding on racism as a source of disparities in prescribing, treatment and policy imp.

Hiring and Retention

- Have the efforts of the subgroups been rewarded and highlighted internally? Does engagement in these efforts advance careers?
- Define competence as the knowledge and skills needed to be inclusive and equitable. Operationalize what that looks like.
- Define competence as the knowledge and skills needed to be anti-racist. Operationalize what that looks like.

NCIPC BSC

- Leadership by scientist-practitioners of color.
- Increase BSC capacity around anti-racism and health equity research and practice by including additional, for example Dr. Uche´ Blackstock, who is a leader in this area.

General Thoughts:

- The presentations emphasized the scope and depth of research and practice that the NCIPC has engaged in injuries and violence that affect communities of color, as well as some policies and policy research. That Dr. Mercy studied choke holds in 1990s underlines that studying these acts of state-sanctioned violence does not lead systemic change. I have advocated for a structural violence working group that would focus on systems and policies that fundamentally support violence against oppressed

communities. I defer to my colleagues, but respectfully suggest that a working group could be convened to focus specifically on police brutality and violence as a product of systemic racism and related ideologies.

Karen Liller: I agree with this focus and a broader focus on structural racism.

David Schwebel: Well stated, Dr. Barnes.

Maria Panero: I hear a gentleman trying to communicate but I guess the rest is not able to hear him.

Liz Habermann: Thank you for your comments, Dr. Barnes.

Dr. Crawford: My mic is muted, although it recently popped up green. Is there another root to call in?

Gwendolyn Cattledge: Dr. Crawford, did you call in with your phone at 800-369-3110, passcode 62487?

Dawn Castillo: There may be issues whether you were put in the "leader" or "participant" group. I said "participant" which may be why I could not be heard earlier.

Tom: Thank you Dr. Crawford. Your comments are clear and very helpful! We need to do more to understand how we got here.

Tonia Lindley: If you are not speaking, please mute your phone line.

David Schwebel: Thanks, Dr Whitaker. I largely agree and see parallels here at UAB to what you describe at Georgia State

Christy Porucznik: Dr. Whitaker has hit on an important opportunity for us as faculty members - to make change in the spaces where we have influence. How might we push to change promotion criteria at our institutions? Explicit recognition of partnership-based science, and community engaged work will help promote such efforts.

Karen Liller: We have practice-based efforts and research included in our tenure and promotion policies at the University of South Florida. Also we are approaching this issue intentionally with our coursework and discussion of structural racism in our courses and outreach efforts.

Liz Habermann: I completely agree, Dr. Cunningham! We need data on PIs of submissions and funded proposals.

David Schwebel: Don't CDC grants go through eRA Commons, and the data are available in eRA Commons? Can NCIPC staff access that information somehow?

Maya Carter: I read about the AIR Pipeline Partnership Program with Howard University, Georgia State, and UT San Antonio. I would love to hear about that.

Christy Porucznik: Can we preclude or discount repeat submissions from majority PIs? Or give bonus points for minority PI? (This may not be ok under review guidelines, but maybe it is time to change them?)

Jim Hedlund: Following up on Dr. Cunningham, how about grants explicitly targeted to minor investigators or minority-serving institutions?

Karen Liller: I agree—these efforts need to be much more intentional.

Donna Barnes: D. Hedlund, that is the ONLY solution! And to include all minority reviewers. We need to discuss this more.

Chinazo Cunningham: The CDC Division of HIV has the "Minority AIDS Research Initiative" which I was a recipient of, and jump-started numerous minority investigators.

Donna Barnes: Examine the possibly of changing policy. It all starts with change.

Christy Porucznik: Bringing in current events, I have seen greater impact of the pandemic on students from underrepresented groups in part because of issues of economic status including childcare access. Considering how “shocks” disproportionately can affect minority populations and how there might be extra supports put in place.

Donna Barnes: Great discussion. Thank you.

Candace Girod: does it make sense to refer back to Dr Frye’s early chat questions and comments?

Christy Porucznik: After I raised my hand, my hand raise option disappeared, so I can't lower it.

Christy Porucznik: It's back!

David Schwebel: Hmm, always complicated!

NCIPC Board of Scientific Counselors
Closed Session
August 20, 2020

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
BOARD OF SCIENTIFIC COUNSELORS (BSC)
Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)

Thirty-Fourth Meeting
August 20, 2020

Teleconference Meeting
Closed to the Public

Summary Proceedings

The Thirty-Fourth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) was convened on Thursday, August 20, 2020 via teleconference and Zoom. The BSC met in closed session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). Dr. Daniel J. Whitaker served as Chair.

This meeting was closed to the public in accordance with the determination that it was concerned with matters exempt from mandatory disclosure under Sections 552b(c)(4) and 552b(c)(6), title 5, U.S. Code and Section 10(d) of the Federal Advisory committee Act, as amended (5 U.S.C. Appendix 2). The Scientific Review Officer explained policies and procedures regarding avoidance of conflict of interest situations; voting and priority rating; and confidentiality of application materials, committee discussions, and recommendations. Committee members absented themselves from the meeting during discussion of, and voting on, applications from their own institutions, or other applications in which there was a potential conflict of interest, real or apparent.

Upon establishing a quorum, a secondary review was conducted for the following NCIPC Notice of Funding Opportunity Announcements (NOFOs):

- ❑ RFA-CE-20-002: Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth

- ❑ RFA-CE-20-005: Rigorously Evaluating Approaches to Prevent Adult-Perpetrated Sex Child Abuse (CSA)

- ❑ RFA-CE-20-006 Research Grants to Prevent Firearm-Related Violence and Injuries (R01)

- ❑ PA-19-272/273 PHS 2019-02: Omnibus Solicitation of NIH, CDC and FDA for Small Business Innovations Research Grant Applications (Parent SBIR [R43/R44])

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the August 20, 2020 NCIPC BSC meeting are accurate and complete:

10/13/2020
Date

Daniel J. Whitaker, PhD
Co-Chairperson, NCIPC BSC

10/10/2020
Date

Victoria Frye, DrPh, MPH
Co-Chairperson, NCIPC BSC

Attachment A: BSC Member/Ex Officio Attendance

MEMBERS
Barnes, Donna H., Ph.D.
Chou, Roger, M.D.
Coffin, Phillip, M.D.
Crawford, Kermit A. Ph.D. Director
Franklin, Frank A., II, Ph.D., J.D., MPH
Frye, Victoria M.P.H., Dr. Ph.
Hedlund, James H., Ph.D.
Herrenkohl, Todd, Ph.D.
Kaplan, Mark S., Dr.PH.
Liller, Karen D., Ph.D.
Porucznik, Christina A., Ph.D., M.S.P.H.
Schwebel, David C., Ph.D.

EX OFFICO
Brodowski, Melissa L., Ph.D., M.S.W., M.P.H.
Castillo, Dawn, M.P.H.
Compton, Wilson, M.D., M.P.H.
Hedegaard, Holly M.D., M.S.P.H.
Joseph, Lyndon, J.O., Ph.D.
Maholmes, Valerie Ph.D., CAS
RADM Taylor, Kelly M., M.S, R.E.H.S.
CAPT. Jennifer, Fan, Ph.D.

CDC Attendees
Gwendolyn Cattledge, Ph.D.
Victor Cabada, M.P.H.
Arlene Greenspan, Dr. P.H., M.P.H.
Mrs. Tonia Lindley
Mildred Williams-Johnson, Ph.D.
Kimberly Leeks, Ph.D.
Karin Mack, Ph.D.
Thomas Simon, Ph.D.
Sue Neurath, Ph.D.
Mikel Walters, Ph.D.

Non-CDC Attendees
Stephanie Wallace, Writer Editor
Cambridge Communications