

Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
BOARD OF SCIENTIFIC COUNSELORS
Third Meeting: January 22, 2010
Chamblee Campus,
4770 Buford Hwy., NE
Building 106, Conference Room 1B
Atlanta, GA 30341

Minutes

The third meeting of the National Center for Injury Prevention and Control Board of Scientific Counselors (NCIPC BSC) was convened at 8:30 AM on January 22, 2010, with Dr. Carolyn Cumpsty Fowler serving as Chair.

OPEN TO THE PUBLIC - GENERAL SESSION

Call to Order, Welcome, and Introductions

Carolyn Cumpsty Fowler, Ph.D., M.P.H.
Chairperson
Board of Scientific Counselors
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Fowler called the meeting to order, welcoming everyone to the fourth NCIPC BSC meeting, and requested that those present introduce themselves. A list of attendees may be found in the Appendix at the end of this document.

Dr. Fowler thanked the BSC members for their participation and hard work. She noted that the Closed Session was taken off the agenda due to time constraints

Science Update

Mick Ballesteros, Ph.D.
Acting Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Safety 2010 World Conference

Dr. Ballesteros explained that the Safety 2010 Conference was a major world conference bringing together stakeholders in the prevention of unintentional injuries and violence from around the world to debate, discuss, and exchange information and experiences. The conference is co-sponsored by the World Health Organization (WHO).

Dr. Ballesteros noted that the Safety 2010 Conference will take place in London, England in September 2010. He added that NCIPC was well-represented in the planning of the conference, and that Dr. Robin Ikeda, Acting Director for the National Center for Injury Prevention and Control (NCIPC), was on the International Organizing Committee, and several NCIPC staff serving on subgroups for specific topic areas such as child injury, road safety, surveillance, and youth violence. In addition, he mentioned that Dr. Ileana Arias would be speaking at the conference during the Opening Session, and that Dr. Linda Dahlberg would be moderating the State of the Art Youth Violence Session.

Promoting NCIPC Research Agenda

Dr. Ballesteros reported that NCIPC is working with the Society for the Advancement of Violence and Injury Research (SAVIR) to assist in the promotion of their research agenda. The goal is to have each division select a topic area from the research agenda. The Division of Unintentional Injury Prevention (DIUP) selected pedestrians, the Division of Violence Prevention (DVP) selected youth violence, and the Division of Injury Response (DIR) selected field triage. He indicated that the purpose of promotion is to look for opportunities to support and improve research in these areas. Projected outcomes include joint funding with CDC and other federal agencies or foundations.

Dr. Ballesteros noted that the goal of each workgroup is to develop a written document regarding research in each topic area, to conduct meetings with potential partners, to look for opportunities to increase or jointly fund programs, and to develop roundtable discussions at conferences that relate to each of the specific topic areas.

TEACH VIP E-Learning

Dr. Ballesteros explained that TEACH-VIP E-Learning is an online self-paced curriculum in violence and injury prevention, designed for health and health and public professionals and other health care providers; staff of public health ministries and non-governmental organizations; and students in schools of medicine, nursing, and public health.

TEACH-VIP E-Learning addresses a broad range of issues pertinent to understanding and preventing injuries, violence, and suicide. It includes extensive content about using data to understand injury problems and creating programs to address these problems.

Learners can choose from 20 lessons to create an experience appropriate to their needs and schedules. Each lesson can be completed in approximately one hour, although optional activities and readings are available that can add to the time needed to finish a lesson.

Dr. Ballesteros noted that in 2007, CDC funded a contract with the Educational Development Center to convert the paper-based, instructor-led curriculum into an electronic version online and a CD version for areas where internet access is limited. He encouraged the group to visit the website because it serves as a great resource and reference for students, local health departments, and practitioners.

Discussion Points

- **Dr. Denise Tate** asked Dr. Ballesteros to provide more information regarding the SAVIR Conference.
- **Dr. Ballesteros** responded that in promoting the research agenda, NCIPC talked about having roundtable discussions at conferences related to specific topic areas selected by each workgroup, and they were trying to determine which conferences would be most appropriate in terms of audience and timing. He suggested that the next SAVIR Conference, to be convened in Iowa City in April 2011 would be a good possibility to host the roundtable discussions.
- **Dr. Shrikant Bangdiwala** commented that if NCIPC wanted to promote the research agenda, the delay in waiting until 2011 would be too long. He asked whether NCIPC could promote the agenda at conferences that would take place in 2010, or if other alternatives were being discussed.
- **Dr. Ballesteros** replied that an issue NCIPC is experiencing is with deadlines to include submissions for conferences. For example, the American Public Health Association (APHA) has already begun accepting abstracts for the 2011 conference, but NCIPC is unfortunately not ready to submit. The time period reflected in the update to the research agenda is 9 or 10 years; therefore, there is no necessity to conduct this in the next several months.
- **Dr. Bangdiwala** asked if there were discussions regarding conducting an on-line, roundtable virtually or via webinar.
- **Dr. Ballesteros** responded that some of the workgroups have discussed those types of strategies. It is a matter of trying to determine what will work for each workgroup.

- **Dr. Deborah Prothrow-Stith** asked what the process was for deciding on the three areas.
- **Dr. Ballesteros** replied that NCIPC started with the same process, and then each group decided based on what they were ready to do. He affirmed that the process was different for each group and that flexibility was permitted.
- **Dr. Prothrow-Stith** asked what would happen to the agenda items not selected, but which people wanted to continue to pursue.
- **Dr. Ballesteros** replied that overall, the priorities were listed in terms of each chapter and content area, but for this specific activity, NCIPC was not trying to make a decision of having just one thing they were trying to assess. He stressed that there were many strategies used to promote the research agenda.
- **Dr. Fowler** commented that in terms of opportunities, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the State and Territorial Injury Prevention Directors Association (STIPDA) have an established webinar series. As the communication infrastructure exists, NCIPC could potentially get on their agendas. Regarding the issue of partnerships with the research agenda, Dr. Fowler encouraged NCIPC to establish their partnerships early in order to leverage political support, funding, et cetera. In relation to TEACH VIP, Dr. Fowler mentioned that WHO conducted a lot of work with Maria Isabel Gutierrez, M.D., M.Sc., Ph.D. in Columbia and asked if she would be assisting with translation.
- **Dr. Ballesteros** responded that they were still looking for resources to conduct the translation. They were currently working with Dr. David Meddings at WHO. He mentioned that the meeting that took place with him last year involved discussion surrounding what options NCIPC may have if they found resources for translation. Dr. Ballesteros stated that his strategy was to converse with Dr. Meddings to engage others within WHO to determine what the most appropriate way would be to move forward with translation.

Research Portfolio Reviews

Michael Ballesteros, Ph.D.
Acting Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Ballesteros gave a brief update of two on-going portfolio reviews, the National Violent Death Reporting System (NVDRS), and the Motor Vehicle Team Portfolio Review (MVTR).

National Violent Death Reporting System (NVDRS)

Dr. Ballesteros stated that a draft of the Portfolio Review Report has been written, but the Division of Violence Prevention (DVP) is in the process of reviewing the document and making revisions. They have not scheduled an external panel meeting, but have begun considering who those members will be. Their goal is to have the panel meeting sometime during the spring, in either April or May.

Motor Vehicle Team Portfolio Review (MVTR)

The purpose of the Motor Vehicle Team Review (MVTR) is to examine research projects of the entire Motor Vehicle Injury Prevention Team, which is one of the two subunits within the Division of Unintentional Injury Prevention (DUIP). He noted that this is different from reviews conducted in the past, given that in the past they selected specific topic areas such as falls, youth violence, or traumatic brain injury. When the Center makes decisions about the reviews, they have a great deal of flexibility in the scope and what they would like to accomplish. The review will include projects from the last 10 years, but will not include biomechanics and ICRC projects because those are covered in other portfolio reviews. Additionally, the review will include both intramural and extramural projects. They are currently in the process of conducting data collection, and making decisions regarding what should and should not be included. The review will cover approximately 60 studies, which is a manageable number. The team has nearly completed data collection and is in the process of obtaining success stories. They have not chosen an external panel or a date, but anticipate that the panel's discussions and revisions to the report will be completed by August 2010.

Discussion Points

- **Dr. David Grossman** asked if the review focused on the intramural research of NCIPC on motor vehicles or if research would be included that was conducted as a part of the R01 Program.
- **Dr. Ballesteros** responded that it will include both. During the early part of the review process, it was challenging to think about the intramural work because some of these projects are secondary analysis of a data set that they have, and they had to determine what and what not to include. It does include both intramural and extramural research, but there were some decisions made about what not to include.
- **Dr. Prothow-Stith** asked how long NCIPC has been conducting portfolio reviews, how many have been completed, what the greatest impact of the reviews has been, and how much reviews cost.
- **Dr. Ballesteros** responded that portfolio reviews are mandated throughout the entire agency. NCIPC goes beyond what other Centers do.
- **Dr. Dahlberg** added that their first review was Youth Violence, followed by Falls Prevention, Biomechanics, TBI, and then the ICRC Portfolio Review. She reported that the initial peer review policy of the agency was very focused on research; however, the revision of that policy

called for the inclusion of both research and programs, and left the discretion up to the Centers to decide the scope, which was why the proposed MVDRS, a large surveillance effort, was included.

- **Dr. Ballesteros** further stated that NCIPC works with the divisions to determine what the topic areas will be. He stressed that while they are left with a lot of flexibility, the challenge is to try to make the reviews something that are not just a requirement / checklist, but that result in actual benefits to NCIPC.
- **Dr. Prothow-Stith** asked whether there were examples of impact, change, or decision making that resulted from previous portfolio reviews.
- **Dr. Ballesteros** replied that when the Falls Review was completed, falls was one of the Center's priorities. The comments and results derived from the review helped drive the direction of Division Unintentional Injury Prevention (DUIP). He affirmed there was an extensive list of recommendations that resulted from the review, and stressed the importance for the group to discuss recommendations that are realistic for the Center.
- **Dr. Fowler** asked if there was an unintended risk to having a long list of recommendations that CDC could never act upon.
- **Dr. Ballesteros** replied that NCIPC does not make the recommendations themselves—these come from an external group. The reviews are supposed to be an internal process for the agency to help improve their programs and research.
- **Dr. Dahlberg** added that there are obviously some recommendations that they cannot necessarily act upon, but with the Youth Violence Portfolio Review, they drew upon the recommendations to inform future funding announcements, inform the research agenda, and produce Department of Health and Human Services (HHS) reports. She said there were a few things that they could point to where they have concretely followed up on recommendations. However, some recommendations are viewed as wish lists, and are taken into consideration, but cannot necessarily be acted upon.
- **Dr. Grossman** requested that Dr. Ballesteros walk the group through the process. He observed that the reviews that were sent to the BSC appeared to have three different groups: an external contractor, a working group that included internal stakeholders, and an external group.
- **Dr. Ballesteros** responded that NCIPC has the discretion with respect to how they conduct the portfolio reviews. Therefore, the reviews that they have conducted in the past and the ones that they will carry out in the future may not necessarily follow the current model. He stressed that the Center has a lot of flexibility in terms of what works for them, as well as available resources. In the past, they have obtained a contractor to assist them with the data collection and report writing, given that it is a major amount of work. There are many challenges with trying to acquire information regarding programs that were funded 20 years ago. For example, with the Falls Review, there were numerous challenges with finding documentation, principal investigators, and other critical information; therefore, utilizing contractors assisted them with the review process. CDC gives the contractors guidance in terms of what needs to be collected,

and depending on the topic area, collaborators within the agency come from a different organizational unit. The purpose is to gather information about what has been funded, what the accomplishments were depending upon the topic area, and to write a report that outlines an overview of the program. That report is given to an external panel that convenes in Atlanta to review the document and provide information regarding the program. As an external group, they develop preliminary recommendations that will ultimately be presented to the BSC. The BSC will sign off on recommendations that they believe to be applicable and that should be put forth to the Center. There are a lot of external groups, with the ultimate goal of CDC receiving recommendations from the BSC regarding how to improve programs.

- **Dr. Vik Kapil** asked about the costs associated with conducting the portfolio reviews.
- **Dr. Ballesteros** responded that other than staff time, the Center typically has a contractor assist them with the reviews. The current contract in place is approximately \$190,000 per year.
- **Dr. Gwendolyn Cattledge** informed the group that past contracts have averaged between \$100,000 to \$250,000 per year.
- **Dr. Fowler** inquired about the return on the investment.
- **Dr. Ballesteros** replied that he did not have an answer, but agreed that the Center needed to determine the return on investment.
- **Dr. Fowler** stressed that as NCIPC offers guidance in terms of reviewing its portfolios, it may be helpful to have very specific questions such as: What partnerships were leveraged? What other funding was used? What was built upon? If the portfolio reviews could be used to help generate funds for the Center, or identify mechanisms through which NCIPC could be more efficient and effective, this would be an added value.

Discussion of Completed Portfolio Reviews

Dr. Mark Redfern
Chairperson
Biomechanics Portfolio Review Panel
Board of Scientific Counselors
National Centers for Injury Prevention and Control
Centers for Disease Control and Prevention

Biomechanics

Dr. Mark Redfern indicated that the rationale for the Biomechanics Portfolio Review is that it is required by CDC's 2003 Policy on Peer Review of Research, and includes both intramural and extramural research activities. The goals of the Biomechanics Portfolio Review were to assess focus, quality, and practice relevance of the research portfolio; identify gaps and redundancies in

the portfolio; assess the outcomes of the research; and identify research findings that should be translated into practice.

CDC has been conducting biomechanics research for approximately 25 years. Biomechanics research is included in five of the seven covered topic areas which incorporate falls, injury tolerances during physical activity, human tolerances for impact (related to playground injuries), motor vehicle crash assessments, and diagnosis of intimate partner violence (IPV) and child maltreatment (CM). The assessment questions for the review included the following:

- 1) To what extent has the body of funded projects been relevant to, and distributed across, each phase of injury research and the priorities of NCIPC?
- 2) What have been the reported outcomes and impacts, especially the successes, of projects in the portfolio and are these outcomes the desired impacts or outcomes?
- 3) Have the funded projects been conducted in a manner expected by NCIPC and the injury research community, and have they yielded the quality of outputs and outcomes expected by the NCIPC and the injury research community?
- 4) Were there opportunities for portfolio expansion or enhancement to fill gaps and avoid redundancies in order to further the CDC and NCIPC research agendas and ultimately reduce the number of injuries in the United States?

In the past, R01s have dominated grant funding in the area of biomechanics, and funding was distributed fairly evenly across geographic regions: West 22%, South 19%, Northeast 26%, Midwest 32%, and Canada 1%. The number of grants that have been awarded in the area of biomechanics has varied widely over the years. In 2006 and 2007, only one grant was funded per year. Motor vehicle biomechanics was the largest funded area, followed by falls, and then sports. Biomechanics got its start in NCIPC in the area of motor vehicle injury, where it made an early impact. Falls became more prevalent about 15 years ago. In the early years of motor vehicle biomechanics, CDC provided funding for the basic research that was necessary to move forward in vehicle development.

Dr. Redfern gave a brief overview of biomechanics product development, noting that there was a strong loss of corporate history in NCIPC from the early days of biomechanics. Therefore, it was essential for the Center to develop a team to conduct research to determine the historical accomplishments in the field. NCIPC had funded six biomechanics-related SBIR grants, all of which developed products. Additionally, non-SBIR grants also resulted in products. These included the Hybrid III female and child crash test dummies, improved head restraint system, and impact-attenuating floors for hip prevention. Biomechanics grantees conducted research that led to important advances in motor vehicle safety. Other products included a drowsiness detecting biosensor, a retro fit device for cervical whiplash prevention, development of a multi-sized Hybrid III based dummy, and development of side impact airbags.

Reducing Hip Fractures by Design was initiated at Penn State roughly 20 years ago. This project is a good example of biomechanics in action, and how CDC has contributed to prevention of injuries.

In 1987, CDC funded Toby Hayes, who was at Harvard at the time, to examine the biomechanics of falls and hip fractures, which led a number of other groups to begin work in the area. In 1996, other groups such as Mayo, UCSF, Yale, Beth Israel, and many others followed up on prevention based upon biomechanics work, resulting in the development of HIP Pad Technology, Flooring Design Technology, and Postural Control importance.

In terms of policy development, the portfolio review stated that “By far, the greatest contribution that the NCIPC-funded biomechanics research made to policy development was in the area of NHTSA’s Federal Motor Vehicle Safety Standards (FMVSS).” The portfolio review also stated that “Biomechanics research is well-positioned to have lasting impacts on the field of injury prevention by training new cadres of researchers to enter the field, and by building the infrastructure and capacity necessary to ensure ongoing research activities.” Additionally, the portfolio review revealed that the money that CDC spent was highly leveraged with other funds, which created lasting impacts.

The problems surrounding opportunities for future biomechanics research are that there are no NCIPC staff members with expertise in the area of biomechanics, and injury biomechanics research exists as an isolated microcosm with little interaction with other injury research activities. The solution stated within the portfolio review was that “CDC should increase its intramural research in biomechanics.” Other problems surrounding opportunities for future biomechanics research include a reduction in funding for biomechanics research in recent years; and that grantees are being asked to work with fewer resources, a situation which could reduce the productivity of projects; and an absence of long-term strategic planning for biomechanics research.

Recommendations provided in the portfolio review included working across the research spectrum in the areas of sports / concussions, whiplash, and child head / neck injuries, and working in biomechanics of child maltreatment. Cross-portfolio recommendations included considering biomechanics when finding solutions; exploring partnerships with the Department of Justice (DOJ); validating and simulating of dummy development, examining the mechanisms of child abuse, studying helmet development, examining pediatric falls and head injury, biomechanics of the injured neck, and studying acute care of neck injury from driving.

Discussion Points

- **Dr. Grossman** requested a definition of “full body biomechanics.”
- **Dr. Redfern** replied that full body biomechanics could be for example: postural control, and how one might maintain integrity of the entire body; or how an entire body gets constrained within a motor vehicle restraint system as opposed to just focusing on the head, pelvis, et cetera.
- **Dr. Grossman** asked if it was possible for the BSC to have a copy of the full portfolio versus just the Executive Summary.
- **Dr. Cattledge** responded that the portfolios were internal documents and only Executive Summaries and Recommendations are usually provided to the BSC.

- **Dr. Fowler** commented that if there are specific questions being asked, at the very least, any piece of the document that would answer those questions should be made available to the BSC.
- **Dr. Redfern** suggested that NCIPC make a policy decision regarding the provision of information that is necessary to the BSC.
- **Dr. Fowler** pointed out that if all the BSC has are recommendations, and they have to prioritize them based on a summary, they would just be guessing. She also asked whether any cooperative research agreements had been established, suggesting that if CDC does not have the in-staff capability, cooperative agreements could be a reverse benefit.
- **Dr. Redfern** replied that he was not sure, reiterating that most of the funding was through R01s during the early years, and that CDC has not funded very much biomechanics research in the last three years.
- **Dr. Prothrow-Stith** asked what else was occurring in the area of biomechanics. She pointed out that perhaps CDC's role in 1987 was more catalytic to attain other attention and funding. If the reduction in funds coincides with an increase in national attention and funding, perhaps this is the role that CDC plays. She felt it was difficult to determine CDC's future role in the area of biomechanics.
- **Dr. Redfern** responded CDC was struggling with this as well. The National Institutes for Health (NIH) funds basic mechanism research in biomechanics, which was the type of funding he would personally apply for because applied biomechanics "falls through the cracks." Car crash biomechanics is being funded by other agencies. Canadians like to fund applied research. He stressed that there is a role for CDC in the area of biomechanics that is not being addressed by NIH and other agencies.
- **Dr. C. Hendricks Brown** noted that one of the major advantages in the biomechanics portfolio was the translational research, or moving into policy and practice. He asked if translation research was an important part of the review.
- **Dr. Redfern** replied that understanding how the foundational work translates forward into some sort of action is important; pointing out that CDC did not realize that other people were using the data for translation.
- **Dr. Brown** expressed concerned that a program with such a great deal of activity was virtually being shut down, leaving no base being built to try to connect CDC's role with moving results into policy.
- **Dr. Allen Heinemann** agreed, pointing out that, with some centers having a greater than 20-year funding history, CDC would need to look back a long time to identify center's accomplishments and the emerging leadership in the field.

- **Dr. Redfern** agreed that the basic developmental work is important, and that it serves as a “seed” that germinates biomechanics today. The Canadians are developing working on Flooring Biomechanics that CDC initiated 20 years ago. The quick turnaround benefits that CDC is looking for are not necessarily what happened in the biomechanics area. It is a more steady progress in which the fruits are now being observed. He understands that CDC is looking for short-term gains, but this is not what occurred in the biomechanics area.
- **Dr. Fowler** affirmed that the comments about translation were really important and that it was essential to determining what CDC’s role in biomechanics really is. She stressed that in order to make the best use of the BSC, the more information the panel receives in advance, the more effective these meetings and recommendations can be.

Injury Control Research Centers (ICRC)

Sue Lin Yee, M.A., M.P.H.
Senior Evaluation Scientist
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Ms. Yee reported on the findings from the CDC Injury Control Research Centers Portfolio Evaluation. She reported that the two-year ICRC Portfolio Evaluation was conducted by the Maya Tech Corporation, Dr. Howard Kress, Ms. Natalie Brown, and the ICRC Portfolio Workgroup.

Ms. Yee gave a brief overview of the guiding questions that were received from CDC leadership, as well as from ICRCs and other stakeholders that were deemed important, which included the following:

1. What is the value of the ICRC portfolio?
2. How has the ICRC program built the injury field?
3. How has the ICRC program affected injury outcomes?

These questions allowed the panel to develop the evaluation questions for the project. In general, the Center looked at the portfolio review as an opportunity to lay out what the research and non-research contributions of the ICRC program were. Because of the nature of the questions, this portfolio review, unlike the previous ones, was very qualitative in nature.

The key contribution of the ICRC program spread out across the following five areas: injury research infrastructure, training, collaborations, leveraging of funding, and multidisciplinary research.

The benefits of collaboration within the ICRC program include multidisciplinary approach that combines expertise, perspectives, and fields of study; availability of data provided by partners; translation of injury research into practice and policy; visibility for Centers; opportunity to pool resources; training for partners; development of community programming and interventions. Without these collaborations, the high quality of the research may have been more difficult. In

talking to the Centers, the panelists determined that without the CDC grant, maintaining collaborations over time would be very difficult.

In reviewing the research findings, over 6000 peer-reviewed publications were reported. Multidisciplinary research included perspectives from engineers, sociologists, criminal justice, public health, medicine, et cetera, and was conducted in all phases of the public health research spectrum.

Ms. Yee presented information pertaining to the Harboview / University of Washington's Community Booster Seat Campaign. The types of activities that were conducted through the different research projects throughout the campaign demonstrated seatbelt syndrome in children injured in motor vehicle crashes, with computer simulation suggesting booster seats reduce abdominal forces. Additionally, the campaign developed an intervention based on focus group findings and used community-based intervention trials to demonstrate the effectiveness of a community-based booster campaign.

Linda Degutis, Dr.P.H., M.S.N.
Member
ICRC Portfolio Review Panel

Dr. Linda Degutis addressed the ICRC External Peer Review Panel recommendations. She indicated that the ICRC program started in 1987, and at that time 4 centers were funded. In 2008, 13 centers were funded for 5 years. The funding per center is approximately \$850,000 dollars per year, which includes all infrastructure, research, and direct costs.

Overall, the ICRC portfolio received praise for its contributions and its ability to conduct and disseminate important injury research, its central role in training students and professionals, its contributions to professional injury organizations such as SAVIR and APHA, and its leadership in editorial boards of injury journals. However, the panel identified substantive areas for improvement that could enhance NCIPC and the field.

The recommendation topic areas included training, collaboration, translational research, advocacy and policy, innovation, global efforts, sustainability, funding process and performance expectations.

The panel recognized that the Center was one of the primary contributors of training to faculty and staff, but also understood that students in various disciplines do not have a lot of exposure to injury prevention and control, and may have a difficult time finding mentors. The panel also found that the training materials and opportunities were developed, but the materials were not always shared and the opportunities were not always standardized in terms of developing core competencies. Panel recommendations included encouraging funding and dissertation research grants for graduate students in the ICRCs. Some recommendations focused on conducting similar strategies for places that were not ICRCs, but may collaborate with them. Separate funding streams were recommended for grants that were external and open to both the funding centers and other academic institutions. Additionally, the panel stressed the need to consider training grant mechanisms that could be funded with dollars outside of the ICRC program to also enhance the field. In addition, consideration

should be given to how they can get students in fields other than public health and other traditional fields exposed to the injury field.

Other recommendations included creating a repository that could serve as a national and global resource so that people would not have to reinvent lectures and curriculum. **Dr. Degutis** noted that there was lots of discussion concerning tracking and monitoring trainings, such as the Harborview campaign, which created a system of tracking and monitoring trainings.

The next area requiring improvement was collaboration. The panel felt that CDC should play a more active role in the coordination, administration, and facilitation of collaboration. The panel stressed that collaborations are not just internal to the ICRCs. Additionally, the ICRCs are not aware of what the scientists are doing. It is critical for these relationships to be developed and enhanced.

Dr. Degutis reported that the panel engaged in a long discussion regarding translational research. The first recommendation was to clarify the definition as it pertained to the ICRCs. The panel felt that Harborview's work was critical to the ICRCs and that there needed to be a focus on translational issues. The panel also recognized that there were a number of issues with the funding process, and that more clarity was needed. For example, in the FOAs, the panel asked for clarification of the requirements, scoring, and funding streams. One of the main areas discussed was creating a two-component review process to eliminate competition between new and well-established centers, and providing an opportunity for new centers to receive funding without taking funding away from established centers.

Finally, the panel found that performance measures were needed for the ICRCs, and that there need to be outcome measures or benchmarks to manage performance expectations.

Discussion Points

- **Dr. Prothrow-Stith** noted that the report was lacking measures, such as the number of legislative policy initiatives, number of Ph.D. students graduating with injury as a focus, or number of APHA presentations on injury over time. She asked if this information was provided in the report, stressing the importance of quantifying the information.
- **Dr. Fowler** asked whether dollar amounts were placed on the leveraged resources and integrated research.
- **Dr. Degutis** responded that the panel did not have any numbers for the trainees and leveraged resources. Since some of the data were not readily available from the centers, the panel made recommendation regarding the ability to track those types of outcomes.
- **Ms. Yee** added that counting Ph.D. graduates is a difficult question. Within the injury field, definitions for injury concentration vary. What they found when they approached the ICRCs with a question like that was that everyone had different parameters for counting. They talked about how some monitoring systems could be put in place so that there would be standardized definitions for certain terms, especially in the training area; so that CDC can help the centers

track that information better for future evaluations. She affirmed that the information regarding leveraging was made available in the report, and that the ICRCs leveraged approximately \$2 to \$8 million beyond their funding.

- **Dr. Bangdiwala** commented that one of the recommendations that was offered for training was to have dissertation grants, and to have an external funding stream separate from the funding from the ICRCs. As mentioned in the report, given that the ICRCs funding has been capped and has been declining for a long time, he wondered whether any strategies had been developed regarding other ways to increase funding. He also asked how the political system had changed with the new administration, and what strategies were being recommended.
- **Dr. Degutis** responded that the major part of the peer review panel's discussion focused on the need to increase the dollar amount of funding overall. The panel agreed that funding programs at a stable dollar amount decreases funding over time, and makes it very difficult for the ICRCs to function. The concern is that there are limits in what an ICRC can achieve. Other strategies include obtaining sources external to NCIPC and related organizations. She stressed that the panel was told repeatedly that there would not be an ability to necessarily increase the dollar amount of funding to the ICRCs.
- **Dr. Fowler** commented that the issue was raised concerning how difficult it was to have policy take place at the national level; however, the presentation revealed very clear evidence of the achievement of policy and landmark policy at Harborview, which is a model for all of the legislation that has followed it in the country. With Harborview being defunded, she wondered how much time was spent addressing costs or financial losses associated with de-funding that 20-year infrastructure.
- **Dr. Degutis** replied that the panel spent time discussing the issue of defunding places that have had a lot of success in research and translating their research into policy. One of the things the panel felt was critical and contributed to decisions regarding funding was the issue of having a succession plan, and having a strong principal director or director for the Center. Therefore, the panel made the recommendation that a strong succession plan be put in place to retain these types of Centers.
- **Ms. Amy Harris** stressed that it was important for the panel to remember that they were discussing the Portfolio Review. While the Portfolio Review does have ties to the competitive application process, they are two separate issues. She said the language being used about the program being "defunded" was incorrect. The program was not defunded, it simply did not compete successfully. This was a competitive application process in which the merits were considered and decisions were made.
- **Dr. Fowler** said she noticed in the recommendations that the panel recommended a separate competitive process.
- **Ms. Harris** responded that it was also important to remember that the Center as a whole is very concerned about some of the points raised about what was lost after an investment of over 20 years. This was one of the reasons they felt a portfolio review of this nature was critical. They

want to think about how to reshape the program in the future, and utilize lessons learned from the experience. The competitive process is very difficult. NCIPC hopes that this portfolio review will help to determine the future direction of the Center.

- **Dr. Grossman** commented that the value of interdisciplinary collaboration within a university setting is historically known for its silo tendencies, and is invaluable and difficult to recreate. In the case of Harborview, funding is used to obtain collaborations that they simply could not have done alone. He thought many of panel recommendations were very sound, and wondered how these should be prioritized. Some of the recommendations are realistic, some require a major amount of work, and some are strokes of pens. Trying to put all of this together was almost impossible without asking: What do we want to do with these recommendations? What are the most important priorities of the Injury Center? Is the most important metric number of publications, leveraged grants, or public policy impact? What is the minimum amount of funding a center needs to survive?
- **Dr. Degutis** agreed and pointed out that the panel discussed all of the issues Dr. Grossman raised. Funding was a major concern to panelists, who shared Dr. Grossman's observations. The minimum amount of funding a center needs to survive depends on what is expected of them and what their priorities are. A great deal is expected of centers for a very small amount of money. Some institutions have indirect rates as high as 65% to 70%. The money available to perform the center functions and the research at those rates is far less than a center that has an indirect rate of 30% percent. The panel felt that a budget of over \$1 million per year is the base needed to conduct the work that is expected.
- **Dr. Grossman** commented that in terms of the portfolio review, a comparative effectiveness perspective should be taken on "what you get out of this" versus "what you get out of other investments."
- **Dr. Ballesteros** responded that NCIPC needs the BSC's assistance with prioritizing the recommendations. Some efforts in the short-term will be very challenging, but what the center can do is rewrite the FOA, outline expectations, metrics, et cetera.
- **Dr. Prothrow-Stith** thought the BSC should be allowed to review the entire report and that metrics should be added. She stressed that the growth in the injury field is documentable, as is CDC's role in that.
- **Dr. Degutis** responded that the panel's guidelines to the BSC is to determine what recommendations should take priority and categorize the recommendations as high, middle, or low priority. She agreed with Dr. Prothrow-Stith regarding quantification and examples of how the centers have been effective.
- **Dr. Redfern** stressed that if NCIPC wants the BSC's input, they have to give them the data and clearly define their role in the process. Since they were not seeing all of the data, it was difficult to ask for input.

- **Dr. Fowler** added that it was understood that there are incredible constraints on what is feasible within the CDC system; however, it is important to determine how the BSC can work within those constraints and still be effective.
- **Dr. Tate** stated in the report, the first page had three basic evaluation questions. She stressed that as a BSC member, she could not answer those questions based on the data provided to her. If there was basic discussion provided regarding how to answer the three questions, it would allow the BSC to help NCIPC to prioritize the panel recommendations.
- **Dr. Fowler** concluded that if the panel were to review the minutes both of this committee and the former ACIPC, the record would show that this issue had been raised multiple times in terms of how to use the BSC effectively in regard to provision of information.

Discussion of Completed Portfolio Reviews

Mick Ballesteros, Ph.D.
Acting Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Ballesteros reported that NCIPC was currently evaluating their Core State Injury Program. This program is run out of the Division of Injury Response (DIR), and funds core capacity-building and surveillance through state health departments. There are currently 30 states funded under the program. The main objective of the program is to build a solid infrastructure for injury prevention and control; analyze, collect, and use injury data; and implement and evaluate interventions and programs. Each program costs \$120,000 per health department, per year. Some states receive competitive supplements to conduct work in specific areas such as traumatic brain injury (TBI), older adult falls, and child injury policy work. NCIPC hopes that it will enhance and improve their programmatic work through the conduit into state health departments.

The Core State Injury Program is an important NCIPC activity that cross-cuts most of the topic areas within the center, and the other two divisions. Dr. Ballesteros said that the Division of Injury Response is in a good position to conduct a portfolio review. When Dr. Frieden came to CDC last year, he set forth priorities that aligned with the Center's priorities, which include local and state health departments. In addition, ASTHO has a Presidential Challenge specifically regarding injury prevention. Most critically, the FOA is currently being rewritten. The Center feels that the timing is right for the portfolio reviews to be impactful and to drive what the Center does.

The Centers have the discretion to determine the scope of each portfolio review, so some of the ones that have been completed in the past may not have to be done in the future. NCIPC is considering very specific evaluation questions to help drive the FOA, and is preparing to do this in a relatively quick time frame.

Discussion Points

- **Dr. Fowler** raised an issue related to choosing evaluation questions, pointing out that when STIPDA conducted an evaluation of the ability of the states to accomplish injury prevention-related initiatives, it was revealed that the states did not have the power to move beyond the political barriers within the state to get things done, nor did they have the power or influence to break down the barriers within the state health system. Recently, CDC published an FOA in the area of Physical Activity and Nutrition, *Communities Putting Prevention to Work*, which required the applicant to have significant leadership sign-on. This empowered a lot of people to solicit support from those who would not listen to them before in order to be eligible to compete. She wondered if through the wording of an FOA, NCIPC could empower applicants to get this done.
- **Dr. Ballesteros** responded they would discuss all of the issues raised and would engage others to help determine the best approach.
- **Dr. Grossman** indicated that the BSC would be open to providing virtual feedback. Given the small amount of money and the challenging resource environment, understanding how to maximize the Centers' gains from the amount of money awarded, and then understanding how those funds were invested was important. He observed that it would be interesting to examine how states that have been most successful have actually used their money.
- **Dr. Fowler** pointed out that given the ASTHO Challenge, NCIPC may want to have a conversation with their leadership before the FOA is written.
- **Dr. Prothrow-Stith** added that as NCIPC begins to assess DIR and the surveillance mechanisms, it may be interesting to examine at their origins as they relate to the ICRCs. The growth of injury in the data systems and infrastructures relates directly to the center funding.
- **Dr. Fowler** asked if the BSC members would be available to be part of this process by phone or virtual methods.
- **Dr. Fowler** stated that the group does not have time to conduct substantive decision making about ICRC priorities. However, she suggested that the group develop potential next steps and timelines.
- **Dr. Grossman** noted that NCIPC has eager volunteers to invest time beyond the time that the BSC spends in Atlanta to assist with prioritization of the recommendations. It would be helpful to understand what the Center's vision is in certain areas. For example, in biomechanics, if the vision is to simply stop the program, there is no point in trying to figure out prioritization of those recommendations. If NCIPC is not sure what the vision is and they need assistance with developing a vision, using the portfolio review as data is another option. He stressed that it was difficult for the BSC to prioritize the recommendations if NCIPC was not clear in its vision. The other option was to divide and conquer—divide the group into subgroups, and meet by phone to pre-process the material that could be presented to the rest of the group. It may be effective to have an NCIPC staff person participate in those conversations to help process the information.

- **Dr. Prothrow-Stith** echoed the need to have metrics in place, and understand that metrics are a part of marketing the work of the centers. Metrics in a review are important because they give a sense of the accomplishments, in addition to a sense of what could be done.
- **Dr. Brown** pointed out that it was difficult to capture everything during the reviews, and it was unrealistic to expect everything to be captured. He stressed that a sense of standards needed be published that explained NCIPC's priorities. A key issue that he noted as being difficult to pick up in the reviews regarded the relationships people have with local and state partnerships. Building those constituencies and being able to move and translate what people do into practice is incredibly important and often gets missed.
- **Dr. Bangdiwala** affirmed that these reviews are very important, and are potential marketing tools. CDC has invested over 20 years into the ICRCs and should be able to show proof of something. Harborview is only one example. It is important to capitalize on the reviews as a way of demonstrating that this has been a great investment, determining the vision of the ICRCs, and moving forward to use that information as potential metrics.
- **Dr. Ballesteros** agreed, but noted that the fear was that a lot of the reviews were driven because they wanted to show the work. The reviews in the past were only able to highlight the accomplishments and work of the program. The Center is looking for more than just a pat on the back.
- **Dr. Fowler** clarified that the group was not declaring that just because a center has been in existence for 15 or 20 years it should continue to be there. She stressed that it was about what they have been able to build during the process of being there. A lot of what gets done does not get done with NCIPC funding. It gets done because with NCIPC's funding, relationships have been built, connections have been made, et cetera. To be able to have specific ways to quantify this information is important. Even if it is not being paid for with NCIPC dollars, there are objective criteria by which centers can be compared.
- **Dr. Ballesteros** responded that the expert panel had the same discussion. He shared that within the Center, they have discussed how they can begin to do more work with metrics. His office does not have the ability to go back and quantify things in the review, and therefore expressed difficulty in understanding what the next steps were. He understood the need to provide the BSC with more direction about what is specifically needed with the recommendations that have been made, and then schedule follow-up communications.
- **Dr. Fowler** suggested that the BSC break into groups, and that NCIPC give the subgroups access to the reports and provide very specific questions that they would like answered.
- **Dr. Tate** reminded the group of the three questions listed in the report and asked if Dr. Ballesteros' team could help the subgroups answer the questions based on what is in the summary report.
- **Dr. Ballesteros** said that they would figure out how they could provide the BSC access to the full report.

- **Dr. Redfern** stressed that the BSC was there to serve NCIPC, and to help them do their job as scientists. If specific questions were asked, then specific answers would be provided.
- **Dr. Fowler** thought one thing that seemed to be clear was the issue of quality of relationships. For example, extramural seem to be quite separate from intramural projects. Building stronger relationships between intramural and extramural efforts seems to be cross-cutting and useful, along with the idea of not just having one project officer, but the potential to build collaborative relationships between some of the centers with certain challenge areas. This should not be a portfolio or activity that was marginalized within a bigger workload.
- **Dr. Grossman** mentioned that in his own experience as a center director, the centers are largely isolated in an extramural branch with relatively slim resources and less scientific expertise. He encouraged Dr. Ballesteros to involve the division directors. Historically, the separation between center work and what goes on there has not been good for CDC.
- **Ms. Yee** illustrated the Implementation Logic Model which they developed to guide the evaluation. She noted that Dr. Grossman emphasized a good point earlier in that ideally, there would be an evaluation plan and clear guidance for the grantees. The evaluation team reviewed several of the FOAs and tried to distill from them the charge, and what they were supposed to produce in terms of outputs and outcomes. There was not previously a logic model for this program, so using the FOAs they developed a skeleton, and discovered quite a bit of information in talking with the ICRCs. She noted that the model was in the report. This was a working document for the team. The ICRCs are engaged in certain basic activities and produce certain things. The logic model was an effort to try to illustrate some of those relationships in terms of what is taking place out in the real world.
- **Dr. Ballesteros** indicated that he will contact the BSC to set a time for a conference call.
- **Dr. Prothrow-Stith** added that the ICRCs are large enough that it may be that the review may go into another category, and she urged everyone to be open to thinking about this possibility. As the BSC has further discussion, they can help prioritize, but because they are so different, there may be room to say that this review has to go longer, be different, et cetera.
- **Dr. Fowler** noted that NCIPC could ask the BSC for recommendations in a specific area (subarea).
- **Dr. Ballesteros** stressed that he needed to be careful that they do not drive what the recommendations are.
- **Dr. Fowler** indicated that if there was an opportunity which would be helpful to the Center, it would be perfectly reasonable for NCIPC to ask the BSC discuss the recommendations based on that need.
- **Dr. Nancy Stout** shared that the National Institute for Occupational Safety and Health (NIOSH) was going through a similar process of having programs reviewed, although the mechanisms were a little different. They utilized the National Academies of Science in addition to their

Board of Scientific Counselors. They asked their BSC to assess the review from the Academies and answer the questions: Was it fair and appropriate? Do you generally agree with the recommendations of the review? If not, why not? They asked the Academies to review the programs in terms of relevance and impact using almost the same logic model, and to score them quantitatively. They asked NIOSH's BSC to review the recommendations because some of them are not very feasible. They used the information to restructure their strategic plan.

- **Dr. David Boyd** added that it is important to say what happened to those centers after they went offline to determine whatever mechanisms were picked up by the community, or whatever aftermath could be argued that these really have a lasting effect. The big question is: Is there life after the fed? Congress may interpret it as bad stewardship of funds if this is unknown.
- **Dr. Redfern** responded that he did not believe CDC used that model, but it should be considered. He indicated that he was part of an NSF-ERC. These have a 10-year life cycle, and are expected at the end of those 10 years to be self-sufficient with other funds. It changes what is being done in the center and forces leveraging.
- **Dr. Fowler** clarified for the record that there is not a time limit at the moment for ICRCs, but it is a competitive process, and it should be reviewed.

The record reflects that all BSC members have volunteered to be part of this process to provide feedback.

Did You Know

APHA Policy

Susan Abramson, M.H.S.

**Associate Executive Director for Public Health Practice and Policy
American Public Health Association (APHA)**

Ms. Susan Abramson recently worked at the School of Public Health and Health Services at the George Washington University (GWU) where she served as a lead researcher and project manager for efforts to strengthen delivery of Medicaid services in the District of Columbia. Her previous experience also includes starting a non-profit organization to create and manage a community health center in Alexandria, Virginia; working on Capitol Hill as a health legislative assistant; and a decade of working in international health planning, project development, evaluation, and health financing for the World Bank, USAID, and UNICEF. Ms. Abramson's education includes a Masters Degree in Health Planning and Administration from the Johns Hopkins Bloomberg School of Public Health and Doctoral training in health policy at GWU. She currently serves as the Associate Executive Director for Public Health Practice and Policy at APHA.

Ms. Abramson explained that APHA is a membership organization with approximately 25,000 public health professionals and state and local health departments as members. APHA tries to

balance two roles: as an association that meets the needs of its members, and as a catalyst for public health activity, advocacy, and legislation on Capitol Hill.

APHA currently has a cooperative agreement with CDC to conduct a number of different activities, which recently included starting a policy center. As they began their work with the policy center, Ms. Abramson was able to meet with NCIPC to discuss working together to create a process for developing a national framework for policy agenda in Injury Prevention and Control. This seemed like an opportune time given the recent change in leadership. APHA is halfway through its first year of the contract, and will be conducting interviews with NCIPC staff and an estimated 20-25 injury experts from around the country.

Ms. Abramson's team is continuing to review the federal agencies that are involved in injury prevention to try to determine what their current priorities are and what they will be over the next couple of years, as well as the relative amount of funds that are going to those particular areas. They have also reviewed the NCIPC website materials, the research agenda, the portfolio projects, state priorities, and have been meeting with NCIPC on a regular basis through conference calls and in-person meetings to update them on recent findings. The end product will be a discussion of all of those materials and recommendations.

Ms. Abramson solicited the BSC for voluntary input to participate in their hour long key informant discussions. Additionally, she asked the group what the role of the research and scientific community should be in the development of a policy agenda for NCIPC, as well as what the interface between the research agenda, the research portfolio, and the policy framework should be. She noted that oftentimes, the research agenda follows the development and enactment of a policy agenda.

Discussion Points

- **Dr. Fowler** asked whether this was a policy agenda that NCIPC planned to pursue on behalf of the entire injury field.
- **Ms. Abramson** replied that they are only focused on developing the process for NCIPC internally and, with selected stakeholders, to develop the policy agenda. APHA is not going to give a document to NCIPC with recommendations. APHA's role is to establish the steps for NCIPC to follow. The outcome will be determined by NCIPC and its stakeholders.
- **Dr. Brown** commented that there is already in existence a great deal of policy around injury prevention in this country that is not being followed. For example, the National Plan for Suicide Prevention is stuck in a process that is not moving forward. He asked what CDC's role was in brokering and integrating those kinds of things with research, and not just creating the policy.
- **Ms. Abramson** clarified that there are a lot of injury prevention and risk reduction strategies / action plans; however, her work relates to NCIPC's policy with respect to determining NCIPC's guiding mission and strategic plan, determining which policies and action plans that they will support, and determining how they select what their priorities are. There is a lot of inconsistency with the NCIPC website, and not all of the priorities were based on good data or

good analysis of the data. Her work is an attempt to make a compelling case for what NCIPC's role should be.

- **Dr. Brown** added that the basic principle of what NCIPC is planning to do is to move science into programs.
- **Ms. Abramson** agreed. She asked if the four or five issue areas that have been NCIPC's priorities over the last several years should continue to be their top priorities, and whether they should continue funding programs at the federal level. She stressed that her goal was to determine what NCIPC's role was.
- **Dr. Brown** responded that the basic principles of what NCIPC should be doing are clear, and it sounds as if APHA's task is to establish a framework for their decision making.
- **Ms. Abramson** agreed that was a very important part of what APHA was doing, but stressed that the principles were not clear. They have interviewed 15 of the 25 experts on their list, and there has been great variation among the opinions about what NCIPC does, what they should be doing, what their principles should be, what their priorities should be, et cetera.
- **Dr. Heinemann** asked if there was precedent with other CDC Centers for conducting a similar analysis.
- **Ms. Abramson** responded that she was not aware of any. She has done similar stakeholder investments with previous incarnations of her work, but not with CDC.
- **Dr. Grossman** pointed out that the scientists should be involved in helping to evaluate and synthesize evidence. The other area scientists could be helpful in establishing the preventable burden of particular types of injuries, as well as helping establish priorities based both on the quality of evidence for the strategy and the preventable burden data. This could help begin the formation of a matrix to help public policy analysts.
- **Dr. Fowler** said she was pleased to hear that APHA was doing this work. She stressed that the use of the word "priority" was dangerous, and given CDC's reputation as being the lead agency in injury, establishing priorities means that everyone may agree to them as being their priorities. States are saying that it has been difficult at the state level to conduct work outside of those priority areas that have been established by CDC. It would be helpful to have, as part of the process of developing policy, APHA expert input into how to gauge what could happen as an unintended consequence. The committee agrees that words are loaded. Even though NCIPC is a national agency, a lot of policy ultimately starts at the state level. She asked whether part of that process was going to consider what NCIPC does in terms of informing policy that may be moving at the state level.
- **Dr. Tate** suggested that how the research agenda and policy agenda should interface related to the level of maturity of a particular field or discipline. When the field is new and in a developmental stage, the priorities are needed up front so that the research will follow policy priorities. But when a certain capacity is reached within the field, the research will provide sufficient data to generate future policies. She explained that it is really a cycle that needs to be

evaluated from both sides. For some of the discussions that have taken place so far, the fields are still developing, so there may be some inherent need for guidance from the top down.

- **Dr. Fowler** asked if the policy was big “P” policy (e.g., regulation, legislation, or institutionalized guidelines for decision making) or small “p” policy (e.g., informal policy, prioritizing and infrastructure).
- **Ms. Abramson** responded that it was a small “p.” However, as part of the strategic plan there will be big “P” pieces as well. Ms. Abramson can be contact by email at susan.abramson@apha.org, or by phone at 202-777-2443.

Transitions at CDC

Robin Ikeda, M.D., M.P.H.

Acting Director

National Center for Injury Control and Prevention, and

Acting Deputy Director

Non-communicable Diseases, Injury and Environmental Health

Centers for Disease Control and Prevention

Dr Robin Ikeda is currently serving as the Acting Deputy Director for Non-Communicable Diseases, Injury, and Environmental Health. In this position, she is responsible for providing guidance and leadership to CDC’s scientific and programmatic portfolios. Prior to this position, Dr. Ikeda served as the Associate Director for Science at the National Center for Injury Prevention and Control (NCIPC).

Dr. Ikeda stated that when Dr. Frieden arrived at CDC, he laid out five strategic priorities for the agency, which were to:

1. Improve and strengthen surveillance, epidemiology, and laboratory services;
2. Strengthen the ability to support state and local public health;
3. Strengthen global health;
4. Emphasize policy and health reform activities; and
5. Address public health issues that have high morbidity and mortality.

Dr. Frieden is a data-driven person, and he recognizes that there are often public health problems that have high morbidity and mortality that do not receive the resources they deserve based on the burden. Additionally, Dr. Frieden spent time over the summer working with teams of people regarding reorganization of the agency to align it with those strategic priorities. In September, he unveiled a new proposed organization for the agency. He also made many notable changes such as the removal of the Coordinating Centers from the organizational chart, and the creation of several new offices that align with the priorities he established for the agency.

There are Associate Directors in Dr. Frieden's immediate office for programs, science, communications, and policy. Dr. Arias, the former NCIPC Director, is permanently serving as Dr. Frieden's Principle Deputy Director. The Office of Public Health of Preparedness and Response (OPHPR) is the new name for what was formerly known as the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER). There have been no programmatic changes within the office, simply a change in the name. The Office of State and Local Support (OSLS) is a new office, which underscores the director's strategic priority to help strengthen state and local public health. Dr. Karen White, Senior Management Official in the State of Washington, is currently acting in this position. The Office of Surveillance, Epidemiology and Lab Services is currently being headed by Dr. Stephen Thacker. There are also newly proposed offices each for Surveillance, Epidemiology, Informatics, Lab Science and Career Development.

Additionally, Dr. Frieden also proposed two Deputy Director Offices that would focus on topical areas, one for non-communicable disease, for which Dr. Ikeda is currently serving as Acting Deputy Director, and one for infectious disease. Staff serving in acting positions spent several months discussing what the offices should and could be. Functions for some of these offices are still evolving, but primarily are to serve as advisor to the director and provide strategic direction for the Centers contained within. The Centers have not been replaced; however, with the removal of the Coordinating Centers there has been a renewal of Center power. That is, with the removal of the Coordinating Centers, there is more autonomy.

Dr. Ikeda acknowledged that all of the transition that has taken place within the agency has had an impact on staffing at NCIPC. CDC will request applications for the position of Director of NCIPC through the federal hiring mechanism called USA Jobs. Applications will be accepted from leaders in the field of injury and violence prevention and control. She requested the BSC's assistance in reaching out to well-qualified scientists and practitioners in their networks who may be excellent candidates for this position.

Discussion Points

- **Dr. Redfern** asked if there were there any Centers that were merged or removed.
- **Dr. Ikeda** responded that within some of the Coordinating Centers, some Centers have been removed from the organizational chart, including the National Center for Health Marketing (NCHM), and Informatics.
- **Dr. Prothrow-Stith** asked if the racial and ethnic diversity within the agency was a priority for the new CDC Director.
- **Dr. Ikeda** responded that the issue has been discussed on numerous occasions at very high levels. With all of the transition and hiring opportunities taking place, it is a key priority for the agency to ensure diversity.
- **Dr. Fowler** asked with all of the disruption, how Dr. Ikeda was getting her extensive workload accomplished.

- **Dr. Ikeda** affirmed that there was a certain pace with which they were now expected to keep up. Dr. Frieden has the right public health perspective, and she is excited about all of the things that he is proposing to do. It is very inspiring to hear him speak about his vision for the agency and the accomplishments that they could make. Even better, injury prevention is one of his high priority areas. Dr. Frieden has spoken publicly and internally within CDC on numerous occasions regarding injury prevention, primarily motor vehicle injury prevention. He understands the morbidity and mortality, and the burden being high versus NCIPC being so small and the dollars allocated for injury being small in comparison as well. Dr. Ikeda acknowledged that the challenge was to determine how they could keep up with the work that they were already conducting, in addition to addressing the increased number of requests. Everyone was feeling the same tension and all are trying to figure out how best to maintain their sanity, yet continue the good work. One of the reasons she agreed to wear both hats was because she understands what is taking place at the Deputy Director level as well as the Center level, and she feels that she can protect the Center to some extent so that people can continue the work that they are doing. She would like to help maintain the work within the Center, and minimize the distractions to the greatest extent possible. In the long term, NCIPC will have to consider how they are structured, and how they respond to requests, which to some extent has happened already. The Center has set up processes so that they may they respond to requests and so that interaction with the Office of the Director is more automatic, and that they do not have to drop everything that they are doing to respond to every request. She stressed that it was a learning curve for the Center and for the Office of the Director as well. It is also important to help them understand what expectations are realistic.
- **Dr. Bangdiwala** thought this could be viewed from two different perspectives. This is a time when there is a lot of transition and therefore many disruptions within the Center, or it is an opportunity for change and for capitalizing on the priorities of the new Director. He urged them to obtain as much money as they could for the program.
- **Dr. Fowler** asked if NCIPC had been thinking strategically about budget increases.
- **Dr. Ikeda** replied that the Center has a Professional Judgment Budget, which they are in the process of working with partners to revise, and has been preparing for those types of scenarios.
- **Dr. Tate** said she was pleased to hear about emphasis on global health. She asked if Dr. Ikeda had a sense for how the Center is doing, particularly in relation to the Haiti crisis.
- **Dr. Ikeda** replied that the Center is still in the process of organization, and that the organizational structure looks very similar to many of the other Centers'. In regard to Haiti, the Center has a number of staff involved in the coordination of those activities. The Emergency Operations Center (EOC) was activated immediately after the earthquake occurred, and staff members from the Center for Global Health serve as the lead. CDC is quite active in the response activities surrounding Haiti.
- **Dr. Brown** asked if the cooperation across the Centers had been helpful or competitive.

- **Dr. Ikeda** responded that her experience had been helpful. She liked the grouping of the four Non-Communicable Disease Centers in that there was already a connection, but now that they are organizationally housed together and are meeting on a regular basis, the relationships are better. In creating the Deputy Director Offices, they were asked to keep the offices small, while still being able to make the connections across the rest of the agency. One of the things that was proposed, and hopefully would be approved, was a global point of contact for the Deputy Director's Office.
- **Dr. Fowler** asked in terms of going outside of CDC whether Dr. Frieden had articulated any approach to liaising with other federal partner agencies.
- **Dr. Ikeda** replied that he worked with Dr. Peggy Hamburg previously in New York City, and they have recently worked to explore opportunities for collaboration between CDC and Food and Drug Administration (FDA). The new Substance Abuse and Mental Health Services Agency (SAMHSA) Director is also interested in meeting with him in the near future. Additionally, a meeting with National Highway Traffic Safety Administration (NHTSA) will take place in the very near future.

New BSC Administrative Tools

Demonstration of Army's Financial Disclosure Management Office

Ms. Cathy Ramadei
Management Analysis and Services Office (MASO)
Centers for Disease Control and Prevention (CDC)

Ms. Janine Bland
Contractor with the Army working on the Financial Disclosure Management Project

Ms. Cathy Ramadei represents CDC's Management Analysis and Services Office (MASO). This year MASO is unveiling a new Financial Disclosure Management process for CDC special government employees. She reported that CDC has entered into an interagency agreement with Department of Defense (DoD) and will begin to utilize the Army's Financial Disclosure Management System. Ms. Janine Bland would provide a live demo for the group.

Ms. Janine Bland gave a brief demonstration of the Financial Disclosure Management (FDM) Project, the Office of Government Ethics (OGE) approved, secure, web-based application that allows a Financial Disclosure filer to file the OGE450 report online, as opposed to filling it out on paper. The system automates and improves the financial disclosure report preparation and electronic filing process by guiding the filer through questions about reportable financial information, validating the filer's data, flagging missing and incorrect information, starting each report with prior report information (pre-population), reducing common errors, and increasing data accuracy.

Ms. Bland noted the important thing to remember is that the site can be accessed from any PC. It is the same information from the paper form. The filer has the ability to edit information and add any attachments. Additionally, the flags page will show what is preventing filer from e-signing their report. FDM also provides an audit trail, along with date and time and who reviewed the report. She pointed out that the view print allows the user to print their document. The user can choose to submit now or later. For technical assistance, please contact the FDM service center at 732- 532-5566.

Discussion Points

- **Ms. Bland** asked Ms. Ramadei if the BSC would be using the typical due date, which is 30 days from the date that the report was assigned.
- **Ms. Ramadei** responded that CDC would begin a new procedure whereby they request entire committees to have the same due dates. For example, if February was the due date for this committee, everyone would be requested file by February 1, or whatever the designated date was.
- **Dr. Redfern** asked if specific instructions and details would be outlined in the information that will be emailed to the BSC prior to filing.
- **Ms. Ramadei** responded that her office will inform them what should be used as the appointment date, and provide other pertinent information.
- Dr. Heinemann asked the estimated time to complete the document.
- **Ms. Bland** explained that it depends on how much information is being submitted. She indicated that the first year takes the longest time, but in the following years the fields would be pre-populated.
- **Dr. Tate** asked if the form could be completed in sections, and if so, should the “wrap up” tab be accessed.
- **Ms. Bland** explained that the report would be accessed normally, information could be added, and then upon logging out of FDM the information would automatically be saved.
- **Dr. Grossman** asked when the committee would have to file.
- **Ms. Ramadei** responded that her office was deciding what month the BSC committee would be requested to file. For the 2010 Financial Disclosure, everyone would be using the new automated system.

Demonstration of New BSC Secured Website

Mr. Theodore Samouris
Information Technology Specialist (Contractor)
National Center for Public Health Informatics
Centers for Disease Control and Prevention

Dr. Cattledge reported that the BSC's requests for the secured website were heard. She informed the group that Mr. Samouris was going to present a brief overview of SiteScape, the new BSC secured website. She stressed that this site could be used as a forum for discussions of things that occur within the BSC, outside of the regular meetings, with capabilities to send emails and documents in a secured environment. SiteScape can be used to host web sites that access shared workspaces, information stores and documents, as well as host defined applications such as wikis and blogs. All users can manipulate proprietary controls called or interact with pieces of content such as lists and document libraries.

Mr. Theodore Samouris reported that the SiteScape CDC Team Application creates a central place to collaborate electronically, create a knowledge base of ideas, draft papers, and activities associated with project areas. He indicated that everyone would receive an email with instructions about how to log in. The website is: team.cdc.gov.

Discussion Points

- **Dr. Bangdiwala** asked if someone opens a document that is a work in progress and makes changes, whether the document would be saved back in the same location.
- **Mr. Samouris** responded that the group has to first decide that they want to give each other that capability. What works best is for the group to use track changes in Word and then re-upload the file.
- **Dr. Redfern** asked if there was a way to load it back down, and it keep track of the versions.
- **Mr. Samouris** explained that if "versions" was selected, it would lock the file and no one else could edit the document while the file was still open, which has created problems for others groups in the past.
- **Dr. Grossman** asked if subgroups could be defined. For instance, if not everyone needs to see the discussion, can a smaller group be established? Additionally, are external notifications disseminated?
- **Mr. Samouris** replied that subgroups could be defined, but he would have to set up the subgroup. He added that if he did not mind everyone seeing the discussion, he just needed to communicate his needs to Dr. Cattledge and a forum could be set up. Additionally, a notification email is set to update the BSC every Tuesday at 6:00 AM. The email is a digest of everything new that happens within the group. It will have a list of anything that has changed, with an embedded link for direct access to the site.

- **Dr. Grossman** asked if there was a directory of NCIPC staff.
- **Mr. Samouris** explained that only the BSC will have access to the site, but the user can access the *Find People* application to locate someone outside of the BSC.
- Regarding the weekly emails, **Dr. Cattledge** stated that if there was no new information to disseminate to the BSC, the group would not receive an email. She also mentioned that administrative assistants can receive notifications, but will not be able to access the site.
- **Mr. Samouris** added that the calendar is a great tool as well. He urged the group to contact him with specific suggestions or questions so that they can make the site as efficient as possible.

Economics in Public Health: Falls Business Case

Vilma Carande-Kulis, D.O., M.P.H., FACOEM
Senior Public Health Economist
Office of Public Health Research
Centers for Disease Control and Prevention

Dr. Vilma Carande-Kulis explained that businesses are important partners of the CDC. More than two thirds of Americans receive access to preventive services through employer-sponsored insurance. About 80% of businesses provide health education services to employees. Health and absence-related costs may account for as much as 30% of payroll.

She explained that a business case is an *ex ante* structured assessment of the quantitative and qualitative performance of one or more interventions from a business perspective. The purpose of a business case is to inform executives, medical, and / or financial officers on the benefits and consequences of investing in health and safety interventions.

There are two (non-exclusive) ways of showing prevention “value” from an economic perspective. One way is to conduct economic evaluations to estimate cost-effectiveness ratios (CER), cost utility ratios (CUR), or cost benefit ratios (CBR) (societal perspective, incremental ratios, use of QALYs and WTP studies). Another way is to use the business case approach to estimate cost-savings and return on investment (tangible measure – ROI – business or program perspective), familiarity.

Various entities might be interested in business cases, such as businesses themselves, for example. ROI is part of their language and business practices. Additionally, public health practitioners in departments of health need to justify their funding to state legislatures. CDC programs are very interested in business cases because they need to justify their funding requests to Congress. Public health practitioners at the community level use the business case as a powerful tool in the translation process because it tells them which resources are the most expensive, informs them of the threshold of effectiveness for an intervention to be economically efficient, and helps to tailor interventions.

Business cases are required when CDC National Centers wish to promote the adoption of health promotion or protection programs by businesses or in a business setting or by communities; and when Congress and state legislatures request an assessment of the financial impact of proposed interventions on businesses and the health care system, or request evidence of accountability. If there are 10 interventions that achieved the same purpose, why not fund the implementation of the 2 or 3 of the most economically efficient interventions?

The steps to conducting a business case incorporate describing the current situation, defining objectives, identifying options, defining the analytic framework, assessing benefits and costs, and identifying preferred options using financial metrics.

Dr. Carande-Kulis stated that approximately one third of community-dwelling persons aged 65 or older fall annually. Between 30% and 40% of falls among older adults result in at least some type of injury. In 2000, the total fatal and non-fatal costs of fall injuries for people 65 and older exceeded \$19 billion in direct medical costs.

In 2005, the National Council on Aging (NCOA), in collaboration with the Archstone Foundation and the Home Safety Council, released a *National Action Plan* to promote fall prevention in older adults. The plan led to the creation of the Fall Free™ Coalition comprised of more than 66 organizations to promote the evidence-based goals and strategies contained in the plan. In 2007, NCIPC partnered with the NCOA to expand its work in building a national network of state-coalitions. In 2008, NCIPC and NCOA entered into a collaboration to develop a business case for interventions that have been shown to prevent falls in older adults.

Dr. Carande-Kulis stated that NCIPC developed a matrix for selecting interventions with high effectiveness and high visibility. Based on NCIPC's experience, they chose to study *The Otago Exercise Program*, *Tai Chi: Moving for Better Balance*, and the *Stepping On Program*.

The *Otago Exercise Program* was first implemented and studied in Dunedin, New Zealand. The effectiveness data came from a randomized controlled trial (RCT) comprised of 117 individuals in the control group and 126 in the intervention group. It is an individually tailored muscle-strengthening and balance-retraining exercises combined with a walking program, that takes a total of four one-hour visits by a nurse, and includes thirty minutes of exercises three times a week, and walking outside the home at least twice a week.

The *Tai Chi: Moving for Better Balance* program involves a one-hour sessions of Tai Chi movements with a warm-up and cool down period. The effectiveness data came from an RCT comprised of 84 individuals in the control group and 91 in the intervention group. The classes were held three times a week for 26 weeks. The program included 24 forms of Tai Chi which emphasized weight shifting, postural alignment, and coordinated movements. The program delivered by Tai Chi instructors using the Yang style.

The *Stepping On* intervention was first developed in Australia. The effectiveness data came from an RCT comprised of 153 individuals in the control group and 157 in the intervention group. It consisted of seven weekly group-based three-hour sessions conducted in a community setting with follow-up home visits, but also included a risk appraisal that assessed how to move safely in the home, hazards in and around the home, and how to remove them. The intervention included

education regarding the impact of poor vision causing falls, effect of calcium and vitamin D deficiencies, and the use of hip protectors, as well as medication management.

Dr. Carande-Kulis then discussed the analytic framework for each of the programs. With the *Otago Exercise* and the *Tai Chi* Programs, effectiveness was measured at the end of one year, and costs were measured over six months. The program benefitted from averting direct medical costs from fatal and non-fatal injuries incurred at the time of death or when medical care was provided.

Regarding *Stepping On*, the effectiveness was measured at 14 months, and costs were measured based on seven three-hour visits. The program benefitted from averting direct medical costs from fatal and non-fatal injuries at the time of death or when medical care was provided.

The benefits of data sources for direct medical costs included costs of fatal injuries from the Incidence and Economic Burden of Injuries in the United States. Costs of non-fatal injuries were based on 1998 and 1999 Medicare fee-for-service Standard Analytical files, while incidence of falls were estimated using several databases.

Average cost of a fall injury, meaning the total economic burden of injuries for that age group, was divided by the number of cases $\$19.2 \text{ billion} / 2,610,300 = \$7,356$. This was adjusted per inflation to 2008 price levels using MCPI= $\$10,662$. Therefore, this reflects the expected costs of a participant that enters into any of these programs.

Sensitivity Analysis is used to provide a more comprehensive picture of the uncertainty associated with data variability and quality. It provides a quantitative assessment of how variations in parameter estimates will affect the values of the financial metrics.

Based on ROI values, interventions to prevent falls in older adults ranked as follows:

- 1) *Tai Chi: Moving for Better Balance*
- 2) *Stepping On*
- 3) *The Otago Exercise Program* for persons 80 years and older

The format of the intervention, mainly due to labor costs, had a marked influence on total costs. Effectiveness had a marked effect on the ROI of selected interventions, for example, the ROI of *Tai Chi* and *Stepping On* rose thirty cents per dollar invested if effectiveness is increased by 5%. The analysis did not take into account potential savings from reducing productivity losses, nor did it take into account the burden of care giving and home care costs, or the effect of intervention effectiveness on the percentage of falls causing injury. Caveats included non-quantitative benefits not taken into account in the ranking of the interventions, increased earnings per share, increased market share, shorter time of product development, improved product reliability, award for service excellence, improved employee morale, improved strategic alliances. Other factors which may influence the approval of a particular investment in a health or safety intervention include how decision makers value prevention, what other companies are doing, priorities among other interventions, current financial and market situation of the company.

Discussion Points

- **Dr. Brown** commented on H1N1 virus and who should pay for the vaccine. Those who benefit from the cost savings are generally not the people who pay. It is mostly the insurance companies. This is an issue with public health.
- **Dr. Carande-Kulis** replied that NCIPC has been working with insurance companies, and they are implementing a large number of these programs even though they may know that they will not capture all of the benefits. She stressed that sometimes qualitative benefits are just as important.
- **Dr. Grossman** commented that it would be extremely effective to see this presentation from different perspectives. Depending upon what the injury is for falls, it does not make sense to do it from an employer perspective because hardly anyone is working at those ages. But it will make a lot of sense to take an employer perspective for some of the other injuries.
- **Dr. Carande-Kulis** agreed. Her objective is to engage employers; however, it was not done in this case.
- **Dr. Grossman** added that from a purchaser perspective, another problem is the time issue. If the insurance companies work on an annual cycle, and the turnaround is 10% to 15% per year, a lot of places will say that it is not worth the wait.
- **Dr. Carande-Kulis** responded that this particular ROI was calculated with the largest amount of months being 14 months.

Annual Update on the Fiscal Year 2009 Extramural Research Program

JoAnn Thierry, Ph.D., M.S.W., M.S.
Health Scientist
Extramural Research Program Office
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. JoAnn Thierry reported on NCIPC's research priority areas of funding, new FOAs, changes in the peer review, accomplishments, and the alignment of their research agenda with their actual funding. She indicated that NCIPC identified several research themes in FY 2009, which included preventing unintentional poisoning, focusing on acute injury care, preventing violence and violence related injuries, preventing sexual violence, child maltreatment, focus on protective and promotional factors for youth violence, and prevention of youth violence through economic environmental changes.

NCIPC reviewed 156 applications last year, and funded 24 new awards totaling more than \$9.8 million. There was a considerable amount of interest in the FOAs and they did receive a large number of applications.

Additionally, NCIPC received approximately \$2.6 million research dollars from the Office of Public Health Research (OPHR) to fund 6 awards focusing on translation research. **Dr. Thierry** stressed the importance of this award because this was not funding from NCIPC's regular budget, but is given to them to support their research agenda. In 2009, NCIPC received funds to support initiatives on child maltreatment, falls prevention, teen driving, and children in foster care.

Dr. Thierry explained that the Extramural Research Program Office (ERPO) has an operational and program budget of approximately \$13.2 million. Of these funds, 83% support research grants. ERPO also manage research funds received from the Divisions for promoting the priority area. The Center spent \$35.5 million dollars on research activities. Of those funds, almost 49% of the budget supports intimate partner violence, sexual violence, and child maltreatment. ERPO currently funds 11 ICRCs.

The 2010 Research themes include preventing unintentional childhood injuries, assessing prescription drug overdose poisoning in adults, focusing on acute injury care, preventing violence and violence-related injuries, preventing youth violence, preventing injury, and preventing suicidal behavior. **Dr. Thierry** stated that four FOAs were published in October 2009, two of which were R21s. The other two were RO1s. It is ERPO's goal to start peer reviewing the applications in February and March, and to have all of the applications completed by the end of March. They expect to have two additional FOAs in the areas of suicide prevention and youth violence prevention.

Dr. Thierry reported a few changes to the peer review system, which includes a new scoring system that will utilize a 9-point rating scale, with 1 being exceptional and 9 being poor. Additionally, they will score individual criteria for significance, investigators, innovation, approach, and environment. There is also a new way that peer reviewers will complete their critiques. They will no longer be able to write paragraphs about the strengths and weaknesses of the applications. Reviewers are being asked to be much more concise and put their arguments in bullet format. They are also generating impact scores, and will be assigned based on the projects' likelihood to have a sustained influence in the field of research. The impact scores that range from 1 to 3 will indicate high impact, those with a score of 4 to 6 will be moderate impact, and those with a score of 7 to 9 will be low impact.

Dr. Thierry also offered a brief overview of ERPO accomplishments. There is a need for their office to strengthen their stakeholder interactions by working to improve communications / collaborations between ERPO staff and NCIPC Divisions, OPHR, the Procurement and Grants Office (PGO), Extramural Researchers, and Peer Reviewers. They are also very interested in improving information dissemination in general. ERPO hosted a series of ICRC Directors Visits and Scientific Seminars in 2009, sent e-mail blasts announcing new FOAs, posted ICRC Success Stories to the website, and have conducted workshops at SAVIR, APHA, SSWR, and IVAT conferences about how to write quality applications when applying for CDC funds.

ERPO has had increased support for joint FOAs across CDC and other Federal agencies such as OPHR, NIAAA, FDA, and HRSA. In addition, all 2009 FOA's were announced for a 90-day period so applicants had the full amount of time to write their applications. They moved to an

electronic submission of applications, and used internet assisted review (IAR) of all applications. ERPO is also very interested in improving their website and have dedicated personnel resources to the cause. They currently post on their website their research awards process, current and past FOAs, FAQs for applicants, abstracts of current and recent awards, success stories: research to policy / programs, as well as provide a place for people to sign up for electronic notification of FOA publications at http://www.cdc.gov/ncipc/email_list.htm

ERPO took the BSC's feedback provided at the last meeting very seriously and thought critically about how they could improve the quality of the applications. There were a few things that they were able to implement in 2009, which included increasing the use of existing funding mechanisms. In the past, there have been many R01s and U01s, which are the cooperative agreement process. They are attempting to increase the number of RETs, which are the translational research awards; the R36s, which are the dissertation awards; as well as the R21s, which is a wonderful mechanism for people that are conducting newer, exploratory research. Additionally, ERPO is in the process of developing their first Program Announcement (PA) with multiple receipt dates, allowing applicants to revise and resubmit options, thus improving the quality of their applications. They are serving as the pilot for the agency, and hope to have **the PRA approved and in the system and released for publication by the end of February.**

Dr. Thierry transitioned her discussion to address how their research agenda has been used to inform funding over a period of time. Their funding has remained relatively stable over the years, and represents about 30% of what goes out the door. Overall, research dollars have decreased slightly from 2005 to 2009, with some increases in the area of intimate partner violence, sexual violence, and child maltreatment. However, it is difficult to distinguish between the subcategories because of how their data are collected. It would take a very long time to go back into those original applications to obtain that data.

Dr. Thierry stressed that the alignment between the research agenda and their FOAs is important. A good example of alignment between the research agenda and the FOA was in the 2009 application entitled "The Child Maltreatment CE09-002: Research Priority Tier 1- C: Evaluating the effectiveness of parenting-focused strategies for preventing child maltreatment and promoting safe, stable, and nurturing relationships." Dr. Thierry acknowledged that they need to do a better job of reviewing what they are funding and making the connection between the research agenda.

Dr. Thierry concluded that they have made a lot of progress in the past year, but there is still room for improvement. As always, they are open to any suggestions to assist them.

Discussion Points

- **Dr. Prothrow-Stith** asked how the suicide prevention community withstood such minimal attention to an issue that has a greater impact on health than youth homicide, and how the Center processes this information.
- **Dr. Thierry** responded that suicide was beginning to receive more attention within the Center, as well as at national conferences and meetings. The experts in the Division of Violence Prevention (DVP) could better address this question.

- **Dr. Linda Dahlberg** agreed that suicide prevention is really important, but it comes down to not having a budget line for suicide like they do for intimate partner violence, youth violence, and child maltreatment. Congress normally allocates funding for suicide prevention to SAMHSA.
- **Dr. Fowler** noted that the BSC is often shown slides of how much money CDC has to distribute, but what would be more helpful is showing the line items since CDC does not have the freedom of choice as to where the funds go. It would be helpful for the group to see a breakdown.
- **Dr. Dahlberg** agreed. She added that with DVSV dollars, there are specific budget lines for DELTA and the RPE program, and those are program dollars and not research dollars. So the amount for the total budget in those lines for research is very small as well.
- **Dr. Fowler** suggested that the requests for input on the announcements be submitted utilizing the newly updated website, which is sure to speed up the process for submittals.
- **Dr. Grossman** complimented Dr. Thierry on the outstanding presentation. BSC members indicated that they agreed with Dr. Grossman and appreciated the content and clarity of Dr. Thierry's presentation.
- **Dr. Redfern** thought it would be beneficial to have information for future discussions in each of these areas pertaining to what other players fund the work, how much they spend, and how NCIPC's piece fits in the puzzle. For instance, with suicide, maybe it is good that another agency picks up 95% of the work that needs to be done, but maybe there is a critical 5% of the work for which CDC needs to take responsibility.

Announcements, Closing Remarks, and Adjournment

Carolyn Cumpsty Fowler, Ph.D., M.P.H.
Chair
Board of Scientific Counselors
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Fowler solicited the group for a potential date for a meeting to conduct the upcoming Secondary Review. She noted that due to numerous scheduling conflicts, it would be advantageous to conduct the next meeting utilizing technology assisted review methods. She thanked the group for their participation, and asked them to contact Dr. Cattledge with dates that they would be unavailable to meet during the months of April and May.

With no other issues raised, the meeting was adjourned at 4:12 PM EST.

Certification

Availability of members and upcoming meeting dates will be determined via e-mail. With no further business posed, the meeting was officially adjourned.

I hereby certify that to the best of my knowledge, the foregoing minutes of the January 22, 2010 NCIPC BSC meeting are accurate and complete:



May 12, 2010
Date

Dr. Carolyn Cumpsty Fowler, Chairperson
Board of Scientific Counselors:
National Center for Injury Prevention and Control

Appendix: Attendance**Committee Members Present:**

Shrikant Bangdiwala, Ph.D.
C. Hendricks Brown, Ph.D.
Carolyn J. Fowler, Ph.D., M.P.H.
David Grossman, M.D., M.P.H.
Allen W. Heinemann, Ph.D.
Fuzhong Li, Ph.D.
Deborah Prothrow-Stith, M.D.
Mark Redfern, Ph.D.
Denise Tate, Ph.D., A.B.P.P.

Committee Members Absent:

A. Brent Eastman, M.D., F.A.C.S.
Nancy Guerra, Ed.D.
Sheryl L. Heron, M.D., M.P.H., F.A.C.E.P.
Lourdes Linares, Ph.D.

CDC Personnel:

Jahlani Akil, M.H.S.A., M.P.H.
Lee Anest, Ph.D.
Mick Ballasteros, Ph.D.
Natalie Brown, M.P.H.
Vilma Carande-Kulis, Ph.D., MSc.
Gwendolyn Cattledge, Ph.D., M.S.E.H.
Dianne Clapp
Linda Dahlberg, Ph.D.
Jim Enders, M.P.H.
Sarah Foster, M.P.H.
Demetria Gardner
Jessica Gershick, M.S., C.H.E.S.
Rodney Hammond, Ph.D.
Amy Harris, M.P.A.
Wendy Holmes, M.S.
Richard Hunt, M.D., F.A.C.E.P.
Robin Ikeda, M.D., M.P.H..
Vikas Kapil, D.O., M.P.H., FACOEM
Karin Mack, Ph.D.
Lisa McGuire, Ph.D.
Sara Patterson, M.A.
Cathy Ramadei
Terica Scott, M.A.
Tom Simon, Ph.D.
Jane Suen, Dr.P.H, M.S., M.P.H.

JoAnn Thierry, Ph.D., M.S.W., M.S.

Sue Lin Yee, M.A., M.P.H.

Federal Liaisons

David R. Boyd, M.D.C.M., F.A.C.S., Indian Health Services

Lisa J. Colpe, Ph.D., M.P.H., National Institute of Mental Health

Mary Ann Danello, Ph.D. U.S. Consumer Product Safety Commission

Thomas E. Feucht, Ph.D., National Institute of Justice

Lyndon Joseph, J. O., Ph.D., National Institute on Aging

Iris R. Mabry-Hernandez, M.D., M.P.H., Agency for Healthcare Research and Quality

Sidney M. Stahl, Ph.D., National Institute on Aging

Nancy Stout, Ed.D., National Institute for Occupational Safety and Health

Others Present and Affiliations

Susan Abramson, M.H.S., American Public Health Association

Michael D'Anthony, Sound-on-Site, Inc. (AV Equipment)

Linda Degutis, Dr.P.H., M.S.N., Yale University

Keshia Johnson-Jones, Cambridge Communications & Training Institute (Writer/Editor)

Michael Perez, B.L. Seamon (Senior Conference Planner)