

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL
ADVISORY COMMITTEE FOR INJURY PREVENTION AND CONTROL

Advisory Committee for Injury Prevention and Control
Crowne Plaza – Buckhead
Minutes of the Forty-Eighth Meeting

January 30-31, 2007

Summary Report



The forty-eighth meeting of the Advisory Committee for Injury Prevention and Control (ACIPC) took place on Tuesday, January 30, 2007, from 1:00 p.m. to 5:45 p.m., and Wednesday, January 31, 2007, from 9:00 a.m. to 12:00 p.m., with Dr. Carolyn Fowler serving as Chair.

The sixteenth meeting of the Science and Program Review Subcommittee (SPRS) took place on Tuesday, June 30, 2007, from 8:30 a.m. to 11:30 a.m., with Dr. Mark Redfern serving as Chair.



Tuesday
January 30, 2007

General Session (Open to the Public)

Call to Order/Introductions/Executive Secretary's Announcements

Carolyn J. Fowler, Ph.D., M.P.H., ACIPC Chair
Director, Injury Prevention Program, Baltimore County Department of Health

Dr. Carolyn Fowler, Chair of the Advisory Committee for Injury Prevention and Control (ACIPC), officially called the meeting to order at 1:00 p.m. She requested revisions/approval of the June 2006 meeting.

Motion

With no revisions offered, **Ms. Diane Moyer** moved to approve the June 2006 ACIPC minutes. The motion was seconded and carried unanimously with no abstentions.

Dr. Fowler then called for public comments. With none offered, she announced that Ms. Beth- Ellen Cody, Drs. Ralph Frankowski, Steve Hargarten, and Mr. Ivan Juzang would be leaving the committee. Certificates and letters of appreciation were prepared for each departing member and were presented to those who were present. Dr. Fowler also welcomed new members Drs. David Grossman, Hank Weiss, and Ms. Robin Wilcox.

Ms. Amy Harris, ACIPC Executive Secretary, directed the members' attention to the resource table in the back of the room. Following housekeeping instructions, **Ms. Andrea Barrett** of Maximum Technology Corporation explained the travel reimbursement procedures.

Director's Update

Dr. Ileana Arias, Director

*National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention (CDC)*

Dr. Ileana Arias reminded everyone that at the last meeting they discussed the Injury Center's priorities and the desire to focus resources to maximize the health impact. CDC has continued to work diligently on that effort, both as an agency and within the Injury Center. There have been a series of eight meetings that have included traditional and new partners and the public to review the goals and objectives and assisting in setting priorities within each of those goals. The feedback provided by professionals, partners, and the public is being assembled by a task force and will be provided to the CDC goal teams who are working on creating the plans for implementing these goals. CDC recently convened a leadership retreat where this information was made available to them. The feedback received pertains to both the content of the goals, as well as the process they are using (or are not using) for reviewing, vetting, and setting up the action plans for those goals. Those recommendations are now being incorporated by those who are working on the action plans. Another version of the action plans will be provided to the leadership of CDC in March.

The goal structure CDC is using is viewed as an incredible opportunity for the Injury Center, given that injury is an issue regardless of whether they are talking about a people, place, global, or preparedness goal. Dr. Arias was confident that NCIPC would do well in the process, but to ensure this, individuals from within the centers and divisions served as members on the teams in order to bring the injury and violence issues forward. The current versions of the goal plans identified a couple of investment areas; that is, what would they do in order to meet those goals? With very few exceptions, injury is one of the two investment areas in each of the goals. In all of the people goals, injury and violence are signaled by the agency as something that they must focus on, address, and prioritize in order to have a significant impact on the health of Americans. In the places goals, injury and violence show up across a number of situations, most notably with respect to healthy homes, communities, and institutions and in the global work as well. For

example, motor vehicle related incidents represent a leading cause of death for Americans when they travel or live abroad.

Dr. Arias then reported on the advances made within the center in terms of the budget, the Performance Assessment Rating Tool (PART), the *Handbook of Injury and Violence Prevention*, determining injury center priorities, and partner meetings.

Regarding the budget, Dr. Arias reminded everyone that Congress had not passed a budget, so CDC was operating under a continuing resolution due to expire in mid-February. It is possible that CDC will continue to operate under a continuing resolution for the remainder of the year. Based on the President's budget for fiscal year 2007 and what was included in the House and Senate mark-ups, NCIPC is essentially being level funded. This is positive in that there were no cuts, nor were there any programs cuts. However, this does represent a cut functionally when inflation is taken into account. Given the continuing resolution, NCIPC anticipates that their working budget for this year will be approximately \$138 million.

An important activity NCIPC has been engaged in recently is a performance assessment under Performance Assessment Rating Tool (PART). PART was created as part of the President's Management Agenda—budget and performance integration initiative. It is a diagnostic tool used by the Office of Management and Budget (OMB) to assess program performance in a systematic, consistent, and clear manner. OMB began assessing programs through PART in 2002, with a goal of evaluating 100% of federal programs in 5 years. 2007 marks the start of a new cycle. The administration views PART as a way of holding programs accountable for use of taxpayers' money: What results are we getting for the funds invested?

PART is essentially a self-study. Upon completing the self-study, it is submitted and reviewed, followed by a visit to the program by an examiner to clarify the information included in the self-study. That document and the examiner's review are then returned to OMB, who ultimately assigns a rating. There is also opportunity for dialogue with the examiner and an appeals process. There are 25 to 30 questions in 4 sections. The questions in each section are weighted and scored 0 to 100. Scores are combined to reach a final rating that is qualitative.

The four key components of PART include: Program Purpose and Design (20%); Strategic Planning (10%); Program Management (20%); and Program Results (50%). Section 4 (Results and Accountability) includes progress on program's long-term and annual measures. This is the most heavily weighted section. A program may score well in all other sections, but if it cannot show progress on its long-term outcome measures, it receives a rating of "Results Not Demonstrated." Although quantitative scores lead to a qualitative rating, the scores are not fixed. Scores are part of the process and an absolute score of 60 does not necessarily mean "a pass" (adequate or better grade). In 2004, only 24% of the programs evaluated received a "yes" in Program Results. In 2005, that went down to 22%. Fortunately in 2006, that increased to 29% of the programs reviewed.

Within the Strategic Planning component, a program must identify current goals as well as long-term goals (e.g., expected accomplishments in 10 years). That is, PART is setting up a baseline that will be used in a review in the future. Therefore, it is incredibly vital to choose appropriate

measures to track the stated goals and determine whether they have been met. The long-term measures NCIPC specified, and which were accepted, in their PART review include: 1) By 2018, impact the victimization of youth enrolled in grades 9-12 by a 5% reduction in unwanted sexual intercourse, a 6.5% reduction in dating violence, a 25% reduction in physical fighting, and a 5% reduction in youth homicide—all of these are Youth Risk Behavior Survey (YRBS) measures, so NCIPC will use that as a primary tool for assessing the extent to which they meet these marks; 2) By 2018, reduce child maltreatment by 5% and deaths due to child maltreatment by 10%; 3) By 2018, among the states receiving funding from CDC, reduce deaths from residential fire to 1.02 per 100,000 population; and 4) By 2018, reduce by 5% the percent change of increase of non-fatal fall rates among persons ages 65+ years in U.S. emergency departments. Clearly, none of the rates at any point are 100% due to whatever CDC does or does not do. Therefore, they have embarked upon a process to determine who they must partner with in order to have the field accomplish these rates.

The PART Rating Scale includes the following: Effective (85-100); Moderately Effective (70-84); Adequate (50-69); Ineffective (0-49); Results Not Demonstrated (No agreed upon performance measures or lack baselines and performance data). By the end of FY 2006, all significant Department of Health and Human Services (HHS) programs signifying 99% of HHS's budget had been assessed through the PART process. Overall, programs representing nearly 97% of HHS budget were rated adequate or better. In fact, HHS reduced the number of programs for which results cannot be demonstrated to only 2.5% from 12.4% in FY 2005.

A lot of hard work goes into the NCIPC program and the PART process, and this clearly transmitted to the examiners and OMB. Dr. Arias quipped that like every good student, NCIPC was shooting for a solid C. Instead, they happily received a solid B. This was very exciting for NCIPC, as their PART scores were comparatively high:

- Injury Prevention and Control: 81, Moderately Effective
- Chronic Disease Prevention: 81, Moderately Effective (a program which has significantly greater resources than NCIPC, and which has been in place longer)
- Birth Defects and Developmental Disabilities: 70, Moderately Effective
- Bioterrorism: Upgrading CDC Capacity: 57, Results Not Demonstrated
- Bioterrorism: BioSurveillance: 58, Results Not Demonstrated

A recent activity of which NCIPC is quite proud is the publication of the *Handbook of Injury and Violence Prevention* (the Handbook). Following up on last year's publication of *The Incidence and Economic Burden of Injuries in the United States*, the Handbook reviews evidence-based intervention programs and applications in depth, to help professionals better identify appropriate, successful intervention strategies. It is the first book of its kind—one dedicated to describing preventive intervention approaches to reducing risks for unintentional injuries and violence. The Handbook also addresses the importance of communicating effectively with the public about injury prevention. NCIPC views the Handbook as a bedrock text for professionals involved in delivering or managing prevention programs, as well as graduate students and researchers, who will benefit from the critical attention paid to knowledge gaps in the field.

With regard to determining its priorities, NCIPC examined its major programs based on key factors such as stakeholder support, demonstrable and measurable impact, feasibility of interventions, burden of injury, evidence base for interventions, alignment with agency-wide goals, consistency with CDC's role, and cross-cutting/far-reaching impact. Prevention of child maltreatment, falls among older adults, and injuries related to residential fires scored the highest in these areas. Programs that were not identified as top priorities at this time will be prepared to be highlighted in the years ahead as they reach different stages of readiness.

A step that the center completed was to develop a logic model so that they could assess where to begin focusing some resources and activities in order to achieve the desired outcome. They quickly realized that for child maltreatment, their current efforts fell more toward the left side of the logic model, rather than the right side. But for residential fire injury prevention and falls prevention among older adults, they were further along the continuum and moving from research into dissemination and adoption. In developing this logic model, and later stylizing it, they strongly felt that partners play a critical role in their ability to affect change. NCIPC knows they cannot do this alone, and that only through collaboration with organizations such as those represented on ACIPC will they be able to improve the health and well being of the public. ACIPC is a partner and Dr. Arias stressed that there would be discussions throughout this meeting about how this body may be able to assist in this effort.

After establishing NCIPC priorities, in order to engage a wide range of external organizations, they convened a series of partner meetings in Washington, DC (e.g., three meetings with the same format). The purpose of these meetings was to assemble the leaders within the field to hear from them what they believe is needed in order to advance the field of injury prevention specific to the three topic areas. This dialogue was important so that CDC could better identify what activities they would champion, making sure to align themselves with the field so that together they could achieve greater outcomes. The meetings were framed around the logic model, focusing most of the conversation on what the field as a whole must do to impact knowledge, attitudes, and behaviors. Central to the logic model are our partners, playing a critical role in NCIPC's ability to effect change. The discussion focused on identification of gaps, assets, and strategies to address these gaps. They then sought commitments from organizations to help advance these strategies.

This group was initially tasked with identifying the gaps; that is, what is missing currently that does not allow the field to have a significant impact in the field? For example, there was the sense that they need to reframe how they talk about child maltreatment in order to make progress, especially as it applies to progress in the political and public arenas (e.g., attaining political and public will to invest in solutions). More specifically, a strength-based approach is needed that focuses on protective factors (e.g., healthy relationships and families; nurturing children inside and outside of families), rather than a focus on the prevention of a bad thing (e.g., child maltreatment; bad parenting).

Related to the issue of framing, there was also a call for developing a unified, coherent approach in the field. They must all speak the same language, focus on the same things, and ask for the same things. Currently, the field is extremely fragmented. The result is that there appear to be competing interests, although there are not. Therefore, it is important to identify an approach

that encompasses as many of those things as possible in order to be more successful in drawing attention to the problem and garnering the resources necessary to address it. Research was also identified as a gap. There was a call for continued focus on the generation of surveillance information in terms of prevalence and incidence, and a continued focus on risk and protective factors, addressing efficacious interventions, and dissemination research. There was also a call for addressing policies—not necessarily laws, but policies at the agency level of the government in order to increase the visibility of the need for prevention of child maltreatment. The last gap identified was the need for leadership; that is, there are many players but there is not any one organization or agency within or outside the government that is the obvious leader or point person for the effort of prevention of child maltreatment.

More time was actually spent on the effort to identify strategies to address the identified gaps. In terms of reframing, it was recommended that they convene major partners (including non-traditional partners, such as those from business and economics), as well as development of materials. The kernel of the message is similar, positive, and relates to the unified approach that they want to promote (e.g., SSNRs, healthy families). However, it was agreed that they need to have different messages for different audiences and that they may need to talk about the “negative” in some cases (e.g., that they are trying to prevent child maltreatment; that child maltreatment has long-term economic and health costs). They also recommended using those convened partners to identify the unified approach, theme, or framework that could be used for communicating about the need for engaging in child maltreatment prevention.

There was a recommendation specifically in the data needs to generate information about health costs associated with child maltreatment, and very importantly to support cost analyses in intervention studies—that it is important to determine the return on investment of the implementation of child maltreatment prevention programs in order to encourage broad implementation of those programs. This is not just about collecting more data, but also is about making data that they have more understandable, useable, and accessible (e.g., synthesize and translate). Integration should be required across state plans at the policy level in order to improve not only the data, but also the efficacy and effectiveness of programs that are implemented.

With regard to leadership, they were told that since no one else is doing so, CDC should “step up to the plate” to take the lead on moving much of this effort forward. Many of the strategies suggested were related to convening partners/stakeholders and for model parent involvement in all that they do. CDC will commit to being a leader with the public health community to address child maltreatment issues, though they recognize that others may be better suited to fill this role in the future. Part of CDC’s responsibility as a leader/convenor is to bring others into these discussions about how best to advance the field. For child maltreatment, this is particularly important with CDC’s other federal sister agencies.

Based on some of the work done by various partners, as well as some of the discussion during the meeting, the proposed unified framework is: The support and creation of safe, stable, nurturing relationships (SSNRs). This is believed to be a frame that will empower rather than alienate parents and caregivers (both potential abusers and actual abusers), and strengthen parenting practices to prevent child maltreatment. This message also makes it more

approachable for policymakers to get involved in the area than if they talk about the prevention of sexual abuse, etc. CDC also proposed to develop unified messages using this framework.

One of the greatest non-traditional and new partnerships to come out of the residential fire meeting is with Meals on Wheels, with whom CDC has not only been talking to about addressing prevention of residential fires, but also about dealing with the issue of falls. The gaps identified during the residential fire injury and death prevention included the need: 1) for better dissemination of evidence-based strategies to increase uptake and implementation of programs; 2) to increase communication, raise awareness, and collaborate to distribute information and smoke alarms to the public; and 3) for increased awareness of the issue of fire injuries as a public health problem (e.g., through firefighters, for example). Strategies to address these gaps were also identified.

Dissemination of evidence based strategies should be supported by implementing and marketing of smoke alarm installation programs; providing technical assistance and training (to include tailoring evidence-based programs); institutionalizing "ownership" of implementation programs among stakeholders (including landlords, residents, homeowners, and renters); engaging the media; and evaluating knowledge and compliance. With regard to increasing communications, raising awareness, and collaborating to distribute information and smoke alarms to the public, the recommendations were to: identify liability issues, offer solutions and focal points, develop partnerships, develop and evaluate best practices, create sustainability with a business plan, and market with the media. Pertaining to increasing awareness of the issue of fire injuries as a public health problem, it was recommended that this be done by involving all interested parties, capitalizing on election opportunities, working with local partners to deliver prevention messages, and collaborating with Project Impact.

As with Child Maltreatment, CDC will commit to being a leader with the public health community to address residential fire injury prevention for this partnership process, but will look to identify others to take the lead. For example, they need to have more in-depth conversations with USFA. CDC will be engaging in the development of a unified message that will be vetted with the partners and others. The initial thinking is that the message will be framed around the concept of having a functional smoke alarm in every home. CDC will also work with partners to identify appropriate messages for policy makers, the general public, fire prevention audiences, business, and others. They will also convene partners to discuss, identify, and leverage the assets and related-activities of each organization. In terms of prevention training development and dissemination, CDC will convene a meeting with key partners to understand what fire safety and prevention (such as smoke alarm programs) training programs exist, what additional training may be required at the local and national level, and how to make training opportunities more accessible and desirable to fire service personnel. Focus groups will be conducted with fire service representatives to discuss these issues. Regarding prevention program evaluation, CDC will identify opportunities for evaluation and effectiveness research on the specific components of multi-faceted programs. They will also work with other organizations that are either currently conducting similar programs or developing new programs that include appropriate evaluation, including program effectiveness and economic evaluation.

Gaps identified in the older adult fall prevention meeting included: leadership; standardized risk assessment tools; knowledge of best practices; public/political will; unified message among partners; evaluation of existing community programs ; research into circumstances of falls deaths; model legislation for state adoption; partnerships between public health, aging, and medical communities; attention at state/local level to prevalence of falls; and national safety standards for walkway surfaces/floors/floor cleaners.

Strategies suggested to address the identified gaps included the following: convene a national conference for partners; link to insurance companies/payments; link to licensing boards for healthcare providers; develop and disseminate a best-practices manual; develop public/private partnerships, identify political and social champions; develop national standards for floor and walkway surfaces; and engage state based coalitions. CDC will commit to engage with key organizations regarding who would be best to lead the public health community and what resources that organization would need in order to do so. Examples of organizations with which CDC needs to have more in-depth conversations are AoA, the private sector, and state health departments regarding engaging community-level coalitions. CDC will engage in the development of a unified message.

In terms of partnership assets and leveraging resources, CDC will assist with facilitation of regular partner communications among partners to discuss a process for maintaining interactions and progress on activities and will collaborate with other government agencies, private sector organizations, the insurance industry, etc. CDC will determine what critical research needs to be examined to improve fall prevention, such as circumstances of falls that result in hospitalization or death; conduct translational research and rigorous evaluation of existing interventions; and explore opportunities for funding to conduct this research in collaboration with partners. To identify and disseminate risk assessment tools, CDC will conduct an environmental scan of scientific information on standardized screening instruments and disseminate its findings; and will conduct focus groups with clinicians and practitioners to determine barriers to using a standardized screening tool for fall risk.

Dr. Arias reported that these meetings were back-to-back, and that they have never had experiences like this. It was not clear whether it was the people they brought together or how it is they are thinking about these issues, but the meetings were incredibly invigorating and CDC staff left the meetings feeling charged rather than tired. There have been incredible outcomes as a result. Interesting to CDC staff was that child maltreatment, prevention of residential fires, and falls are at very different points in terms of how much support they currently have, and how much consensus there is on effective interventions. However, regardless of the topic being addressed, there are certain themes that always emerged as necessary to address and then the groups charging CDC with pushing those (e.g., leadership, unified framework messages, increase in political/social will).

CDC developed reports regarding the gaps and strategies to address them which were identified in each of the meetings. The reports were sent to the individuals who participated in the meetings to ensure that what CDC heard was correct, what they were proposing to do themselves or get the field to do was appropriate, and to determine next steps for moving forward. CDC has proposed working with other federal agencies in these areas to inform them about the current

thinking and to determine what they can all do to align their agenda for 2009 or 2010 in order to accomplish the goals set for each of these areas. In the case of child maltreatment, they have already engaged in discussions with the Health Resources and Services Administration (HRSA) and the Office of Child Abuse and Neglect, and are identifying others in order to coordinate activities.

There was tremendous enthusiasm in the child maltreatment follow-up phone call. Participants identified next steps for CDC as well as for themselves. CDC will now propose a workgroup structure in order to include not only those who have participated to date, but also other potential partners. In the residential fire injury and death prevention follow-up conference call, there was a significant amount of input and commitment to making it happen. There was positive reaction to what CDC documented from the initial meeting; that is, to ensure that there are functional smoke alarms in every home. In addition to identify other federal agencies that may have a role, they are also in the process of trying to bring what they have developed thus far to the Fire Safety Council (FSC), which has done great work in terms of moving the field forward.

The enthusiasm was not as great with respect to older adult fall prevention, so CDC is grappling with why that is. Part of the problem seems to be that the organizations who are working on the prevention of older adult falls are also working on many other activities, such as nutrition and physical activity issues among the elderly. Consideration must be given to how to focus on falls without taking away from other important activities. Fragmentation stands in the way of getting consensus on the "one ask," making it significantly more difficult to identify the unified messaging framework. CDC is now in the process of proposing a workgroup structure to address this issue specifically before moving forward. They are also attempting to determine how they might work with the Falls Free Coalition, which has a national agenda and has done a lot of work for the prevention of falls.

Pertaining to next steps, CDC will serve in a leadership role within these priority areas until they identify an organization more appropriate and which might be more effective in these areas. They are in the process of finalizing the reports, which they anticipate will be distributed by February 1, 2007. Once completed, these reports will be disseminated more widely to gain additional feedback and increase collaborative work within CDC, across federal agencies, and across non-federal agencies. This is a very exciting undertaking, given that as a field of injury and violence prevention experts have an opportunity to make a difference. The time is now, at least in these three areas due to where they are in terms of the science and infrastructure. Dr. Arias stressed how proud she is of the work done by the NCIPC staff and publicly offered them her gratitude. Essentially, not only have they been thinking "outside the box," but also, she has been forcing people to *act* "outside the box." This is an extremely difficult process, and it does sometimes mean taking attention and effort away from other duties. She also stressed that ACIPC is one of CDC's major partners, and she personally invited them to be equal partners in the enterprise of moving these priorities and areas forward.

Discussion Points:

Ms. Diane Moyer said she thought the continuing resolution was going to be based on 2006 funding.

Ms. Harris responded that different theories were circulating, with some speculating that it will be at the FY 2006 level, others that it will be at the FY 2007 mark, and still others suggesting that it will fall somewhere in between those two. Regardless, NCIPC believes it will fall somewhere around \$138 million.

Ms. Billie Weiss inquired as to whether the residential fire meeting addressed policy in terms of smoke alarms.

Dr. Arias responded that policy was raised in the context of sprinklers, in that if the field really wants to prevent fires and associated injuries, routine installation of sprinkler systems is required. However, there are numerous associated policy challenges. Meeting participants stressed that the focus should be on something that could be done immediately. Given that people typically will not fight smoke alarms, that can be used as a "foot in the door" to supporting codes for sprinkler systems.

Dr. Ralph Frankowski noted that the CDC guidelines for public health research over the next 10 years focuses on about 10 areas. He wondered how this integrated with NCIPC's research topics and ACIPC's role in the reorganized structure and how they could best work with NCIPC to move these goals forward.

Dr. Arias replied that the proposals for the three areas have been made, but NCIPC has not yet embarked on engaging in any of the activities, so ACIPC can offer their advice prior to any action. CDC has established goals across the life stage, places, etc. These three areas (child maltreatment, fires, falls) are NCIPC's contribution to that. For example, if they want to ensure that there are healthy adolescents, consideration must be given to how NCIPC's expertise and resources can be used to make that happen. The feedback on those goals and how that works not only is done locally in terms of ACIPC, but also through involvement with CDC-wide committees. One issue which has not been addressed as much until recently is the research program integration. There has been a great deal of focus on goals and health impact, which begs the question: What programs are available and how will you support the programs in order to achieve that health impact? Efforts must also be made to determine how to make a difference in other focus areas as well, such as suicide prevention.

With respect to Dr. Frankowski's inquiry regarding whether the ACIPC structure would remain the same, **Dr. Arias** indicated that there was a proposal to change the structure of committees at CDC to have one main advisory committee for CDC with very broad representation, as well as subcommittees which would address the goals of CDC. To deal with the programs at centers, there was a proposal to create a Board of Scientific Counselors (BSC) that would be charged with evaluating programs and research portfolios of the centers. It is not clear whether this will be for the coordinating center, or if the coordinating center would choose to have a BSC for each center. In their coordinating center, they have suggested that there be two BSCs: one for Injury

and one for Environmental Health. Until NCIPC hears otherwise, the structure of ACIPC will remain the same.

Ms. Harris added that she did not believe there was clarity on how they would go about expanding the membership of the overall CDC, although NCIPC was asked to provide names and suggestions about how they would populate the subcommittees and the BSC. If this goes forward, anyone selected to be a member of a subcommittee or BSC would have to be reconfirmed by HHS. It appears that this will be a rather long process.

Dr. Flaura Winston inquired as to whether NCIPC had a budget laid out. For example, if they were going to solve child maltreatment, how much would that cost and who would pay for it? She also expressed concern that while there is tremendous excitement about the work to be done, if there are no dollars, everyone will soon be discouraged.

Dr. Arias responded that they are working to identify what needs to be done, who will do it, and what resources will be required. They have discussed how much would be needed for falls and fires and have costed that out, although more work is required to figure this out for child maltreatment. Through their discussions with others interested in these topics, they hope to coordinate activities and leverage resources. Certainly, new resources must be identified as well.

For falls, **Ms. Harris** indicated that the number they have been sharing with people is \$30 million, and they are in the process of developing professional judgment to answer the cost questions more clearly in order to reach the goals of 2018.

Speaking from a personal viewpoint rather than his employer, **Dr. David Grossman** noted that traditionally CDC has had the view of public health and has considered the medical sector to be another part of America, which is clear in every local health department. His sense is that America is attempting to merge the two. NCIPC's three areas have promise and interest in the healthcare community, and a persuasive argument can be made that these belong on the map for healthcare providers, health insurers, and purchasers. His reflection as a former injury center director is that the best buys are not even on the table. With that in mind, the health care sector should be considered with respect to proposed partnerships. One of many avenues for this is the integration of injury control into the prevention agenda for quality measures, an NCQA measure; that is, what value are we getting for our healthcare dollars? There may be avenues through CMS, for example. To the extent that they can get some of these issues imbedded into the code, that would be beneficial. Employers, healthcare insurers, and healthcare providers understand the evidence and economic arguments.

Dr. Arias responded that they were taking these issues into consideration. She reported that one of Meals on Wheels' successes was making a business case to the primary provider, Humana, regarding the medical costs they save as a result of having those meals delivered. As a result, Humana pays for the meals and the delivery of the meals. Meals on Wheels suggested approaching Humana about supporting the falls and fires prevention as well.

Given that a very small part of the NCIPC budget is being devoted to suicide, for example, **Dr. C. Hendricks Brown** expressed concern about Dr. Arias's analogy of "aim for the moon." Without a solid strategic plan about how to move to the next level through the four criteria, it is not clear how they will raise the other programs and areas of interest they would like to move forward, but for which there are limited resources. Rather than being "among the stars" they could come crashing to the ground.

Dr. Arias replied that suicide had been especially challenging because they have had a small piece of the pie for so long. If they are going to adhere to the criteria, which were chosen for compelling reasons, if a particular program does not have an evidence base, they must identify what to do in order to move the needle further up on that dimension. They are going through this process for all programs: If this is the landscape of what is available, consideration must be given to what they should focus on so that people will say, "Yes, CDC should do that and receive resources for it." They must also position that in the context of what others are doing, some of whom have considerable resources for a particular area.

Dr. Rodney Hammond added that it is critical for partners to speak up about what they would like CDC to do and what they will get behind, which is especially true for suicide.

Ms. Nancy Bill emphasized the importance of CDC including American Indians and Alaskan Natives as they seek to work with partners on the three areas.

Dr. Fowler concurred; pointing out that Indian Health Services has some of the best injury prevention and training in this country.

Ms. Moyer agreed that goals to include American Indians and Alaskan Natives are laudable, but she cautioned CDC to bear in mind that there have been tribal set-asides in order to allow tribes to deal with their own issues as they see fit, so any approach with culturally specific communities must acknowledge that and be tailored and crafted appropriately.

Although \$30 million is being quoted as a ballpark figure for falls, **Dr. Fowler** pointed out that on the resource table there is a report on the incidence cost of falls in 2000, with direct costs being \$2 billion for fatal and \$19 billion for non-fatal falls. With that in mind, part of the messaging to the healthcare industry should be that this is costing X and CDC is trying to deal with it for \$30 million. Moreover, they need to raise the priorities within CDC.

Mr. Bill O'Connell, from the National Safety Council, made the observation that when he sat in on the CDC goal setting meetings their colleagues in the audience were asked to rank a number of issues across CDC environments. There were several injury issues listed among many issues to be ranked. However, out of about 40 to 50 items, injury came in across the board with each goal no higher than somewhere in the 30s. This means they must convince their own colleagues across the isle at CDC as well about the scale of the cost-benefit issues.

Dr. Fowler pointed out that when seeking external partners, consideration should be given to other issues upon which they could overlay one of the three priorities, rather than raising them as separate new issues. For example, healthcare insurance companies and healthcare agencies

already understand that tobacco is a major problem that is costing them billions of dollars per year. NCIPC can say, "You know this is an issue, and by the way, it is the leading cause of fatal house fires, non-fatal burns, etc."

Dr. Hank Weiss suggested that just as they framed child maltreatment prevention with a positive, strength-based approach, they could frame falls prevention with a strong and healthy aging message.

Dr. Fowler reminded everyone that during the last ACIPC meeting, they engaged in extensive discussion about the risks and benefits of prioritizing. They also had an extensive discussion about the use of words. With that in mind, she expressed concern about the word "priority" for the three priorities. ACIPC members and many people in the field know that NCIPC is aware that these are not the only priorities. Given that NCIPC is seen as the voice for injury, if they state that they have three priorities, they run the risk of the rest of the country assuming that these are the *only* priorities. Perhaps instead they could use the term "focus areas." Also of concern to Dr. Fowler was that while it is fabulous that CDC is perceived as a leader for these areas, *leadership* will be mistaken for *ownership*. That is, rather than being seen as a leader, facilitator, catalyst, etc., these may be perceived as CDC's (or the public health world's) problem to fix.

Mr. Jerry Reed and others agreed. He stressed that they must determine how to help the outside world understand that just because other areas are not priorities, they are still active areas of interest within NCIPC. Consideration must also be given to how they can raise the currently non-priority areas to the priority level.

Dr. Denise Tate stressed the importance of inclusion/exclusion criteria with respect to who will become partners and their importance in taking these to the next level. Raising Congressional awareness is pivotal in moving the focus areas to the next level in order to garner support for funding.

To address concerns about other important injury issues not included as priority areas (e.g., suicide, teen driving, etc.), **Dr. Arias** stressed that NCIPC continues to say that other areas are issues and they continue to work on them. However, all of the violence programs they have are not at the same place in terms of knowing what to do about them. By showcasing what they can actually deliver they will be buying support to address some of the other issues; that is, they chose areas that could show an observable, concrete health impact in a relatively short period of time so they can then buy some will to address other issues that are more difficult. NCIPC is still working diligently to keep other issues alive and to set the stage for growing them further than they are in order to raise them to the same stage as falls, fires, and child maltreatment prevention in terms of efficacy, effectiveness, and implementation.

Dr. Winston suggested that perhaps the three areas are probably "priority intervention areas" and that they need to develop the top three "priority research areas" based on leading causes of injury morbidity and mortality. She also pointed out that perhaps CDC is not right for some areas, such as teen driving, but that does not mean they cannot serve as the bridge between public health and the development of teens and transportation.

In response, **Dr. Arias** stressed that they must be careful because there are some research needs in the top three areas that should not go unanswered.

Dr. Fowler reminded everyone that another discussion which took place during the last ACIPC meeting was the need for CDC to embark upon an audit of what injury prevention research is being conducted by other agencies/organizations. She encouraged NCIPC to follow through with such an audit. This is not only an obvious area to find funds for prevention, but also for graduate students.

With respect to an inventory, instead of merely gathering information, **Dr. Redfern** encouraged NCIPC to develop a document that could be shared with other agencies in order to help fill in the gaps. For example, in falls, the National Institute of Aging, the Claude D. Pepper Older Americans Independence Centers (OAICs), and NSF are funding work.

In her presentation, Dr. Arias discussed four performance accountability measures and three priority areas. With that in mind, **Dr. Grossman** requested clarification regarding why youth victimization was an accountability area but not a priority area.

Dr. Arias responded that this was the result of negotiations with their own Financial Management Office (FMO) and OMB. Within the PART review, there are various definitions of a "program." A program could be a center, which is how NCIPC approached the review. Resources are also taken into consideration. Rape Prevention Education (RPE) is mandated. Youth violence was included in response to the OMB's requirement for including the large programs as well in order to assess their accountability.

Dr. Fowler pointed out that one lesson is to take into consideration how, for example, RPE got to the place that it is mandated and how they could reach a similar place with public advocacy that would result in mandated support of other injury areas.

Ms. Weiss added that with RPE, there was a considerable amount of training being delivered to the public health and community-based workforces that resulted in gaining a public health focus in rape prevention. With that in mind, she wondered whether existing national and other training initiatives would continue.

In response, **Dr. Arias** said that they have not been able to hold those programs harmless as they are receiving level funding, which is really a cut, and achieving the health impact they are being mandated to achieve. So, they continue to try to determine other sources within CDC that they can mold to address some of those issues that they cannot do directly. One problem is that, although they went through the restructuring 2 years ago, things are still shaking out in terms of who has what with respect to jurisdiction, mandate, resources, and what they can take on. They have now hired a permanent director of Office of Public Health Practice (OPHP). A major initiative they would like to implement is the development of portals for the delivery of best practices and promising practices to health departments and community organizations to deal with whatever issues are necessary. The director of that office just began in the fall, so they are still in the process of figuring out their mandate, how they can work with Health Marketing and the Office of Workforce and Career Development, etc., to address issues of providing best

practices and to address other infrastructure issues such as training. NCIPC has made small investments in some training issues and they are considering other ways to make that same small dollar amount go further than it is currently.

Dr. Hammond responded to the question about mandated RPE, PREVENT, and other training. He noted that they had the good fortune in the RPE and other communities of being asked to provide training for prevention. When stakeholders value what NCIPC has to offer and they ask for it, support is easier to obtain. Garnering support is a complicated issue and it is not clear how they could control that with any particular action or if it was merely luck.

Regarding whether the funding will continue specifically for PREVENT, **Dr. Arias** indicated that it is an on-going program. The division will consider what has been done, what needs to be done, and what other things need resources before making a decision. They want to do it all because all of it is important, but they have to prioritize functions (e.g., training, surveillance, etc.,) also. Perhaps consideration should be given to what functions should be laid over the three topics. NCIPC is in the process of developing a mission and vision statement for each program they have. Perhaps the focus of the next ACIPC meeting could be to review those to determine whether what members think is important outside of the top three is being addressed.

Mr. Reed suggested that they consider the next level of support. For example, the National Violent Death Reporting System (NVDRS) has been an incredible benefit to the suicide prevention community. Because of it, they know things now they never knew before. They can say with conviction that one in five suicides is a veteran, which opens up an entire new partnership potential with Veterans Services. There are many things NCIPC does that can still be translated to their partners in the field that will keep them energized to do what they have to do, and to call for additional resources if the right moment occurs, for example to go beyond 17 states to 50.

Dr. Carol Nicholson thought that NCIPC's focus on using the public health model had been working and would still be an appropriate way to look at the functions overlay. In the three areas, they already know the problem, they have seen the data, they know the causes, they know the interventions that work, and they simply need a transfer blitz to get people to change their behaviors, adopt interventions, etc. With respect to what can be done to raise other areas to priority status, if accelerating the health impact was the criterion for deciding upon the three areas, that is probably the answer. It appears that they focused on issues that were near the public health cycle and right for producing impact. Dr. Nicholson thought that how NCIPC's role was perceived (e.g., ownership versus leadership) would depend upon how NCIPC couches things with their partners; that is, when they develop strategies, they should be national strategies in which NCIPC can play a role, while there are roles for other outside partners as well. Perhaps they could form a council on which they have key partners taking responsibility and action in these areas.

Dr. Arias responded that from the outside, it looked like they were doing both. In order to tackle any issue, they must have a comprehensive understanding of what is necessary. They first must gain insight from others in the field about what the field needs first. Then NCIPC must

weigh in on what they can deliver and seek input from the others in the field about who can deliver other components.

Science and Program Review Subcommittee (SPRS) Update

Mark Redfern, Ph.D., SPRS Chair

Department of Bioengineering, University of Pittsburgh

Dr. Mark Redfern reported on the highlights of the SPRS meeting convened earlier in the day. There were three topics on the SPRS agenda: 1) The Extramural Research Program Office (ERPO); 2) Biomechanics and Traumatic Brain Injury (TBI) Portfolio Reviews; and 3) NCIPC Research Agenda Revisions.

Dr. Rick Waxweiler reported on the ERPO, the feedback for which was generally positive from SPRS, and which he planned to present to ACIPC later in the day as well.

Drs. Charles Magruder and Paul Smutz updated SPRS members on the Biomechanics and TBI portfolio reviews. Numerous portfolio reviews, which are mandated by CDC to be conducted CDC-wide, are underway in the center to look at what has been done in the past and collate that information such that it can be used to look forward. The review processes for Biomechanics and TBI portfolio reviews are taking a formatted approach based on reviews already completed in Violence and Falls. The Biomechanics and TBI reviews will evolve into reports that will be available to ACIPC members. Reiterated from the previous meeting was that the center must do a better job at records keeping of their research projects: What is being done? What are the products? Who are the people involved? It was eye opening for many people to look back at what was done 10 to 20 years ago and realize that information was difficult to determine. With that in mind, NCIPC is also attempting to develop a system for tracking the work being done in order to have complete information in the future.

Drs. Robin Ikeda, David Sleet, and Linda Dahlberg updated the SPRS members on the general recommendations for NCIPC Research Agenda Revisions. The main question that was posed to the SPRS members following the presentations was: Is there a need for major changes or minor modifications to the research agenda? As a result of the SPRS deliberations about this issue, a general recommendation was made for minor modifications, with some caveats. There was also agreement and a recommendation that there is a need for translational research to be brought to the forefront, made explicit, in the agenda. That is, there is a need to take certain projects into translational research as opposed to basic research. A question also arose regarding breadth versus depth in the research agenda. The agenda currently has a number of items that the center would like to do. The same issues surfaced during the SPRS meeting as surfaced earlier in the ACIPC meeting about the need to focus the many issues that need attention based on limited resources. At the end of that discussion in the SPRS group, there was the sentiment that NCIPC should keep the breadth in the research agenda, but develop a process for defining focus areas. This shows the world that CDC is interested in a breadth of areas, and offers a framework from which they can talk to constituencies and other agencies. The final point pertained to considering new forums for stakeholder input for the agenda itself. Among various other suggestions (e.g., town hall meetings, Internet conferences), the National Institute for

Occupational Safety and Health's (NIOSH) National Occupational Research Agenda (NORA) agenda setting process was recommended as a potential model. The group also discussed developing partnerships as a component of developing the research agenda.

Discussion Points:

Dr. Tate inquired as to whether they had a timeline for publication of the reports for the portfolio reviews.

Dr. Redfern replied that the draft reports for the biomechanics and TBI reviews are to be completed in June 2007. The timeline on the final draft for the areas previously reviewed is about the same.

Dr. Fowler asked whether they have a dissemination plan for those reports.

Dr. Sleet replied that they have had discussions about how to share the results. They want to identify the right partners in terms of who would be most interested and what the purpose of sharing the information would be. For example, would it be information for policy development? They have been invited by the *Journal of Safety Research* to devote an entire issue to the Falls Portfolio Review recently completed, which they are pursuing as a mechanism for disseminating the results. He welcomed additional dissemination suggestions.

Extramural Research Update

*Rick Waxweiler, Ph.D., Director
Extramural Research Program Office (ERPO)
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention (CDC)*

Dr. Waxweiler reported on NCIPC's extramural research with respect to FY 2006 activities and FY 2007 progress. He reminded those present that during the June 2006 meeting, SPRS and the Advisory Committee for Injury Prevention and Control (ACIPC) reviewed and recommended FY 2006 extramural research funding for eight Funding Opportunity Announcements (FOAs). NCIPC followed those recommendations and funded \$8.45 million for 26 grants and cooperative agreements out of the 204 received. This represents a 13% success rate for applicants. Total FY 2006 extramural research funding, including continuations of existing awards, was \$34.6 million. SPRS resoundingly recommended that NCIPC not fund Small Business Innovative Research, given that none of the applications met the standard quality expected; therefore, did not fund this category.

One highlight **Dr. Waxweiler** emphasized about this year's new funding regarded the group of four acute injury care grants. These are the first awards responding to NCIPC's Acute Injury Care Research Agenda published in 2005, which was developed under the leadership of **Drs. Rick Hunt** and **Richard Sattin** with SPRS input. All four awards in this category address applied research topics: Evaluation of the American College of Surgeons (ACS) field trauma triage criteria on mechanism of injury; development of clinical decision rules for when to use CT

on children to diagnose abdominal injuries; and two evaluations of the efficacy of post traumatic stress disorder interventions (PTSD)—one in children and one in adults. The latter is an integrated program developed by the American Trauma Society (ATS). These projects are consistent with the overall NCIPC portfolio shift the last few years toward identifying effective interventions pre- or post-injury or violence. Two of these grants are with major CDC partners (e.g., ACS and ATS), which aligns with CDC's efforts toward building partnerships.

Another highlight was the funding under the Urban Partnership Academic Centers of Excellence (U-PACE) FOA of two new Youth Violence Academic Centers of Excellence, bringing total funding of the ACEs up from about \$7 million to \$8.4 million for 10 centers. The ACE program complements NCIPC's 12 ICRC research centers—a program that has maintained fairly stable funding. These are two very strong Center programs NCIPC is supporting over time.

Dr. Waxweiler shared a graph reflecting extramural research funding and total funding to research centers (ICRCs and ACEs) from 2002 to 2006, noting that they classify some of the funds going to centers as “non research” in its functional use (e.g., surveillance; evaluation). Overall, NCIPC funding for extramural research (including all centers, research cooperative agreements, and research grants) has also remained fairly stable for the last 3 years at \$42.6 million in 2004, \$41.9 million in 2005, and \$41.3 million in 2006. This does not include research contracts, which are typically considered to be intramural research. **Dr. Waxweiler** explained that the sharp drop from \$47.4 million in 2003 to \$42.6 million in 2004 was due to the natural conclusion of the Multi-Site Youth Violence Prevention Project.

With respect to other developments, a couple of years ago, there was a desire by **Dr. Julie Gerberding** and the Department to make CDC's extramural research appear seamless to academia. This has involved the adoption of various National Institutes of Health (NIH) software packages and procedures, and modification of those procedures as needed to fit CDC's unique needs compared to NIH. Uniform policies are being set across CDC for how extramural research should be carried out. This month, CDC approved its first new Coordinating Center-based Extramural Research Program Office (ERPO) mandated by **Dr. Gerberding** as part of her priority to enhance and expand extramural research at CDC. The Center is proud that this new office is within NCIPC. As the Director, **Dr. Waxweiler** reports to both the Director of NCIPC and the Director of the National Center for Environmental Health (NCEH)/Agency for Toxic Substances and Disease Registry (ATSDR). A CDC Office of Public Health Research (OPHR) provides policy guidance and oversight to all CDC ERPOs. They are in the process of filling six vacancies that are currently filled by contractors and individuals on temporary detail to them as this organization was being created. Their Initial Review Group (IRG) now has the added responsibility of peer review for extramural research awards for NCEH/ATSDR, although this will not affect the role of SPRS.

Another major change this fiscal year is that NCIPC is spreading out the FOAs into four cycles to even the workload, which will likely be a trend CDC-wide. By 2008, the tentative plan is to develop three deadlines a year, similar to NIH's open announcements. This does not mean that CDC will be making the same announcements three times per year, given that they are not at this level of funding. Hopefully one of the benefits of this process will be a reduction in overhead costs, which they do plan to monitor. This will require that both the IRG and SPRS/ACIPC

convene more often during the year for secondary reviews. NCIPC expects to carry out these secondary reviews by telephone to reduce costs and burden on SPRS/ACIPC members' time.

FOAs have been fairly consistent over the years for the ICRCs, Violence, Dissertation, and Biomechanics grants. With respect to the more specific research cooperative agreement FOAs in cycle C, **Dr. Waxweiler** reported that NCIPC Research Funding Opportunity Announcements FY 2007 include the following: Impact of TBI Among Incarcerated Persons; Family & Dyadic Focused IPV Interventions; Maximizing Protective Factors for Youth Violence; Abusive Head Trauma Prevention; Understanding Bullying & Sexual Violence Perpetration & Their Joint Outcomes Factors; and Falls Prevention Dissemination Research.

NCIPC has also contributed dollars to cross-cutting CDC extramural research funding overseen by OPHR. In addition to NCIPC's FOAs, with NCIPC's input, OPHR is overseeing the awarding of about \$20 million in new extramural research this year. NCIPC has been adding notices of these to their list serve members as they are published. The K01 FOA was published January 8, 2007. In past years, they have seen their NCIPC financial contribution leveraged two-fold into OPHR research grants focused on injury prevention and control. NCIPC hopes the same leveraging will occur this year. CDC OPHR research FY 2007 Concept Proposals include the following: Public Health Dissertation Research; Mentored Research Scientist; Graduate Research Training Program; Dissemination of Worksite Health Promotion Projects; and Translation Research—the crown jewel in this portfolio, given that the trend is toward moving beyond intervention evaluation research and into every step of research that must be carried out in order to get everyone in the world to use that same intervention.

Regarding cross-cutting research and how OPHR determines topic areas, **Dr. Waxweiler** reported that each center was asked to define its priorities. Rather than a topic approach, some centers took a more general approach. NCIPC tried to align with the center priorities, which were presented to SPRS during previous meetings. The overall announcement merely states that these would be priorities given some sort of special consideration, and there is not quantification with any special points. Practically any topic that relates to anything to do with public health could be covered by this concept. The applications for these announcements will not be reviewed within NCIPC's review process. OPHR is setting up their own review panels similar to NIH's Center for Scientific Review. OPHR would like to carry out all reviews for all of CDC; however, there is sentiment amongst centers that this approach is too far removed from the subject content areas. NCIPC has their own reviewer data base and believes they have the institutional knowledge for what constitutes appropriate reviewers. For the cross-cutting research, OPHR intends to ask each center for nominations for reviewers, so NCIPC will have the opportunity to submit reviewers' names with unintentional, violence, translation, and other research backgrounds. Although the center will have some form of input into the secondary review, it is not entirely clear how that will be conducted or whether SPRS will be involved.

Discussion Points:

Dr. Allen Heinemann stressed the importance of funding dissertation proposals as a mechanism for keeping the pipeline flowing with our successors.

Given that CDC is sharing a database with NIH, **Dr. Fowler** suggested that this would be a good place to begin the documentation on who is doing research on what.

Dr. Heinemann inquired as to whether grantees funded by CDC are publicly available via a website.

Dr. Waxweiler replied that the Injury Center grantees' abstracts and contact information are on the Injury Center website. While they plan to update the layout of the website, currently this information can be accessed by clicking on "Funding" and then "Extramural Research."

Referring to the ICRC research over the last 6-8 years, **Dr. Weiss** pointed out today's dollar is worth about two thirds of what it was in 1995. They must keep in mind also that the number of centers is going up while the level of funding is about the same. Based on that, Dr. Weiss took issue with the word "gangbusters" for the level of research for those centers, because it is not. All centers are hurting constantly and the hurting increases every year as resources remain the same. They must address the fact that real dollar amount of resources they receive to maintain those centers has been going down consistently.

Dr. Waxweiler responded that if they went around the room, they would probably hear a similar story from everyone about the lack of funding. He thought this was where the real value of the ACIPC committee came together—working with NCIPC to figure out how they can create a "rising tide for all boats."

In addition to turning to former grantees as potential reviewers of applications, **Dr. Heinemann** wondered whether they had other mechanisms to identify qualified reviewers.

Dr. Gwendolyn Cattledge indicated that they receive CVs and, using a criteria system, they assign each potential reviewer a rank from one to five. For new reviewers, they receive names from a host of sources such as from ACIPC member referrals, at conferences, and from other referrals. They have also sought input from 77 professional organizations. She invited those who knew individuals interested in serving as reviewers to send her their CVs, clarifying that those who sit on ACIPC would not be eligible themselves.

Partnership Project Announcement

*Christine Branche, Ph.D., Director
Division of Unintentional Injury Prevention (DUIP)
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention (CDC)*

Dr. Christine Branche indicated that she was making an announcement on behalf of **Ms. Marilena Amoni** from the National Highway Traffic Safety Administration (NHTSA) in the Department of Transportation (DOT). Dr. Amoni is an ACIPC federal agency expert who was unable to attend this meeting. The World Health Organization (WHO) has designated April 23-29 as Global Road Traffic Safety Week. This is a wonderful, continuing interest that WHO initiated first with the designation in 2004 of World Health Day. Dr. Branche disseminated a

description of that week, and stressed that she wanted to ensure that those in the injury community who have an interest or want to make some sort of segue to the traffic safety problem globally and in the United States can take advantage of this designation. WHO has also decided to focus on the young road user. In the United States, that would be the teen driver. In other countries that would be primarily pedestrian, bicycle, motorbike, and motorcycle users.

During that week, WHO will also convene a youth assembly, with designees from each country who will participate. **Dr. Branche** and Ms. Amoni wanted to make certain that all of their partners involved in the public health component of injury knew this week would be available, and perhaps could take advantage of toolkit information available on WHO's website, as well as information that will be available through the Injury Center. The Injury Center and NHTSA are working together to design those products, and the *Morbidity and Mortality Weekly Report (MMWR)* will contain an announcement and article. Their colleagues at NIOSH will also do some similar work with them. Where before the DOT led by NHTSA and HHS with some leadership from CDC were the ones to forge the way, given that there are so many diplomatic issues involved, they are pleased to say that the Department of State is now engaged and there is a three-part interagency group led by the Department of State to deal with diplomacy issues and give this problem the attention it deserves and is overdue.

Preview of Wednesday's Discussion on Partner Activities/Conclusion/Adjourn

Ms. Harris indicated that as soon as the reports generated from the partners meeting were completed, they would email them to the ACIPC members. She also reviewed the agenda for the second day of the meeting, pointing out that the final session would allow an opportunity for further input and feedback on the set of questions contained in their packets.

Dr. Fowler invited anyone who could not remain for the second day of the meeting but wished to contribute input to do so.

Mr. Huber said that while he did not have as much to contribute to the specifics regarding focus, he thought some version of focus made sense. He said that he did have a particular interest in the communications topic on the agenda for day two. Communication is critically important and is a major lever that CDC has to do great work with limited resources. CDC has a tremendous reserve of information, assets, and credibility. A news article appeared on the front page of *USA Today* that morning that reported that traffic fatalities are down, which is huge news. At least some component of that is the tangible result of a lot of work that a lot of people did and it gets a lot of coverage. If CDC played a role in that, they should feel really good. If they did not play a role, they should be asking: What about that should we be doing to garner that kind of attention on these other issues?

While he stressed that he did not mean to be critical, and he recognized the brilliance at CDC and around the table, when he read "The Theoretical Base" of communication theory around the "Socioecological Model," Social Learning Cognitive Theory," "McGuire's Hierarchy of Effects Model," and so forth, he thought it was similar to what would happen at OnStar if they let the engineers who patented all of their technology market all of their technology. A question he would ask (because they ask themselves this all of the time at OnStar on the shameless commercial side of their business) is, "If someone's only job were to make important all of these issues that this center thought were important to do, and bring them to life in a way that created the momentum of the multiple groups that would have to do this beyond the \$138 million budget, would they come at this completely differently?" While he did not know if that would be right or wrong, or if it would be disrespectful to science, it would have an impact. There is a fulcrum, a lever, \$138 million, and the other work has some amount of force to apply. There are wonderful ways to unlock what is buried deep in the way CDC describes things, which can have a lot of power.

With no further business posed, Dr. Fowler officially adjourned the first day of the ACIPC meeting.



Wednesday
January 31, 2007

General Session (Open to the Public)

Call to Order

Dr. Fowler, Chair of the Advisory Committee for Injury Prevention and Control (ACIPC), officially called the meeting to order at 9:00 a.m.

**Report from Working Group for Coordinating Communication
Objectives and Strategies across the Injury Prevention Community**

*Ms. Amanda Tarkington, Acting Deputy Director
Office of Communication Resources (OCR)
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention (CDC)*

Ms. Amanda Tarkington reported on the Working Group Meeting for Coordinating Communications Objectives and Strategies across the Injury Prevention Community, discussing it from two perspectives: 1) in terms of how communications activities are aligning with the bigger picture issues that Dr. Arias described during the first day of the ACIPC meeting; and 2) based on work within the Office of Communication Resources and with the rest of the communication people in the divisions to engage in some coordinated communication efforts. These two efforts are now blending in a very exciting way, so they have some serendipitous results as well. Ms. Tarkington noted that she had spent most of her career working in the Office of the Director, so her audience primarily had been the director and the other employees in that office. Being in Injury has allowed her to work much more closely with the science, with the people who are doing the actual work, and with how what they do can impact public health.

The Working Group meeting was part of a larger strategy for communication efforts within the center. Everything they did during the meeting focused on three things: 1) the day-to-day communication work must be evidence-based to increase effectiveness; 2) the need to prioritize in order to target resources; and 3) the need to engage in the strategic planning that the center as a whole was doing, and for CDC/NCIPC leadership within communications to have a strong role in that. Ms. Tarkington acknowledged that **Ms. Marsha Vanderford**, Director of the Office of Communications, has been the guiding and inspiring force behind all of this work.

Three of the tools used in the Working Group meeting to help reach their goals will also apply to all of the work done in communications. This meeting was an opportunity for them to test them with people who could offer a lot of good feedback. Each of these tools builds upon each other. The first tool is the Communication Objectives Model. This is a conceptual framework based on relevant health communication theories that organizations use to conduct communication

planning across injury issues; that is, what is the objective? The second tool is the Communication Objectives Check List, which is used to determine decisions that must be made to reach the objective. This tool reveals the gaps, which helps to focus on the most effective things to work on. It is a transition from theory to practice that helps in the development of injury- and audience-specific communication strategies. The third tool is the Strategy Guide for Meeting Communication Objectives, which helps to make decisions based on the identified objectives chosen with the checklist: Am I going to ride in the Hummer or the Van? How many people will be in the Hummer? How fast will we drive? Is everybody wearing a seatbelt? The partners were eager to use these tools, it worked well, they got it, and it helped them get to some useful steps in the whole meeting.

Ms. Tarkington clarified that the Theoretical Base slide to which Chester Huber referred at the end of the first day was just to let ACIPC members know that they did base what they were doing on sound communication theoretical models. Every model was integrated into the planning as they created the tools. CDC has wonderful resources to offer for communication, and has made some amazing products and changes in the field of public health through its communication efforts. She used the analogy that a roller coaster really cannot be fun without some good engineering behind it, which is what this is.

The timeline for coordinated communication is being woven into some large efforts that mesh well with the centers. They had already started working on this several months before the Working Group meeting in order to have a unified strategy behind their efforts that matched up with the center efforts. In tandem with the coordinated communications effort, the center as a whole has also been engaged in various efforts. The Office of Communications is a tributary that is about to join into that larger stream.

The messages that they heard from the three partners meeting earlier in the fall around the focus areas of fires, falls, and child maltreatment were that:

- Communication is important in order to meet injury goals, and to create social and political will in support of injury issues;
- There are some common challenges in developing political and social will;
- It is important to have a unified voice and message; and
- They need to have one "ask" when they go to audiences.

Having a unified voice and one "ask" were pondered and discussed during the Working Group meeting. Every discussion and exercise they had was in support of figuring out the evidence-based, prioritized, strategic efforts. They discussed common communication challenges that go across all injury issues; the known universe of audiences, including identification of the top three audiences based on who has the greatest influence in terms of moving injury issues forward; communications objectives, including exercises to determine high priority objectives; and possible ways to frame injury issues.

In the first exercise, communications challenges were addressed. A list of identified challenges was sent to partners prior to the meeting so they could review it. During the meeting, participants were asked to review that list and tell NCIPC whether they were on target, tweak

what was there, or add in anything they thought was missing. The communications challenges that came out of the meeting were many.

A few of those, not in any particular order, are as follows: 1) Need for constant vigilance and maintenance of safety behaviors (rather than one-time action); 2) Policy makers do not fund injury programs at a level commensurate with the magnitude of the problem, perhaps because they believe other problems are of more concern to their constituents; 3) Injury communities are often in silos, not unified; 4) Difficulty advertising our successes, promoting ourselves; 5) Public perception that people are responsible for injury (lack of sympathy and support); 6) Perceptions that policies will limit personal freedoms; and 7) Lack of knowledge that solutions exist that can reduce the impact of injury.

The next exercise was to identify the top three target audiences. They had a discussion about who in each partner's world they would say was an audience. The list was long, so they then engaged in an exercise to narrow that to the top three. They were given the criteria for choosing people they thought would have the most influence in moving injury issues forward. The group's choice of target audiences included the public, State Legislators and U.S. Congress, and national professional organizations. At this point, they divided the group into these target audiences where they remained for the rest of the two-day meeting.

Ms. Tarkington shared a sample of the first tool, the Communication Objectives Model, noting that this is the tool that helps to show where someone is on the trajectory toward change. It is split into two levels—the top layer is for individual and interpersonal level change and the bottom is for organizational, community, and societal level change. The goal is to get to reductions in injury-related morbidity, mortality, and disabilities. While most people would want to begin in Step D of this model (e.g., increase safe/healthy behaviors among at risk populations . . .), there are several steps before this: Step A: Increase awareness of the problem . . ., Step B: Increase awareness of the desire for solutions . . ., and Step C: Influence perceptions of benefits and barriers . . . She invited feedback, noting that they would incorporate it into the next iteration.

Regarding the Communication Objectives Checklist, the following sample questions were posed: 1) What is the prevalence of injuries among people in the jurisdiction for the audience?; and 2) What are the levels of awareness of prevalence among members of an organization, agency, or policy-maker audience (include accurate and inaccurate)? If there is a gap between prevalence of injury and awareness of prevalence, increasing awareness of injury prevalence is likely to be an important communication objective. Identifying the gaps helps focus on the communication areas that will yield the best and biggest opportunities to make changes that are effective. There are gaps that communication cannot address, such as an engineering problem for which an engineering intervention is required. However, even with that example, communication could at least help raise awareness of the problem and perhaps build some consensus change about policy around it.

Within the center, they used a teen driving and parental influence as a case study to demonstrate the model. They asked the lead in the communication area in the Division of Unintentional Injury Prevention to craft a synopsis of the problem and effective interventions. From that

analysis, they used the checklist and discovered that there was a significant gap. They found that parents were monitoring their teen's driving behavior, but they were not looking at the highest risk behaviors (e.g., driving with a lot of friends in the car; driving with distractions). Driving with distractions was the highest risk behavior. Based on that, their communications council in the center recommended that they focus the campaign on giving messages to parents to inform them of what the highest risks are. While that is not the only gap, it seemed like one of the most effective places to intervene. Thus, this was a very useful exercise for them.

In the meeting, they next got into the target audience groups and managed to use the tools to get to high priority objectives for each:

General Public

- Prevalence of injuries overall and among subgroups.
- Levels of awareness among high-risk populations or their interpersonal influencers.
- Risk and protective factors related to injury.
- Level of awareness of risk and protective factors among high-risk populations and their interpersonal influencers (both accurate and inaccurate).
- Consequences (health and non-health related) of injury for high-risk populations.
- Perceived level of personal involvement or relevance of injury for high-risk populations and their personal influencers.

State Legislators and U.S. Congress

- Perception among members/leaders or organizations/communities and/or policy makers concerning public health's role in solving the problem.
- Perceived benefits for implementing proven/promising injury prevention among members of organizations/communities or policy makers.
- Additional benefits valued by the audience that can be associated with behaviors that reduce injuries.
- Mechanisms to strengthen social norms related to adopting the injury intervention and weaken norms related to inaction.

National Professional Organizations

- Prevalence of injuries among people in jurisdiction (area of concern, legal jurisdiction, community area, etc.,) for the audience (organization, agency, or policy maker).
- Consequences (health and non-health related) of injury for organizational, community, social (OCS) audiences (Note: These consequences are likely to be non-health related for OCS audiences and may include high medical costs in a community, liability for failure to protect constituents or workers, etc.,).
- Perceived level of relevance of injury for OCS unit.
- Barriers among OCS audience to adopt intervention to reduce injuries.

The last tool used in the meeting exercises was the strategy guide for meeting communication objectives. Basically, what it guided them to was that framing would be one of the most

effective ways they could go to the next step. There is a section in the guide for each objective to go through the following steps, and many more: message strategy, material design and format, message location, communication channels, source (spokesperson) selection, and evaluation criteria.

There were two people in the group who had done some framing work in their organizations, and they were generous enough to share presentations about their work (National Scientific Council on the Developing Child and Prevent Child Abuse America). **Ms. Tarkington** noted that the information she was sharing with the ACIPC members about the framing exercise either came from one of these two presentations or from the FrameWorks Institute. She encouraged everyone to visit the site www.frameworksinstitute.com. Frames are basically viewpoints used to understand an issue. For instance, if people view injury as unpreventable accidents, they will not really hear any kind of solution. If professionals in the industry can focus on that and help people see that injury is a preventable public health problem like other public health problems, then they can hear solutions. Framing is one way to change how people look at social and individual problems.

Often what comes across is drastically different from what was meant to be communicated. That most often has to do with how the audience is framing the issue. It does not have anything to do with how eloquently the message is delivered or how well-known the target audience is. It is important to know how best to get through so audiences can hear what is being said and embrace it. Examples of how differently a message can get translated follow:

You say . . .	They believe . . .
<ul style="list-style-type: none"> • Environment matters. • Poverty holds kids back. • The problems is struggling kids. • Government programs support families and children. 	<ul style="list-style-type: none"> • Self-determination is key. • Will overcomes adversity. • The solution is better parenting. • Government intervention is for those who are failing.

Some of the basic points is that starting with the positive is important. As scientists and researchers, they are so used to starting out describing what the problem is, followed with numbers that can be horrific to audiences who are not researchers or scientists. When audiences see that, it turns them away because they do not have a way to link back to a solution or connect with what that means. If the problem is with an individual, people do not feel that they have a place in that solution. It is that person's responsibility to fix it. If the problem can be defined as systemic, taking the focus away from the individual, then people feel they have a place in the solution or at least in describing how there might be an effective intervention. Simplification is also crucial, meaning that they need to explain the science or the issue in a memorable way that deepens awareness and leads to a logical conclusion about a solution. One way to do this is through social Math. For example, the commercial in which they say, "You would have to eat X bowls of cereal to get your daily recommended doses of Vitamin D," and the waiter is stumbling around with 50 bowls of cereal. People get that and know what to do. Institute would say to simplify so that whatever the challenge is, the solution is inherent in communicating it.

An example of reframed information shared during the meeting was a question that the *New York Times* asked, "Do you think that single mothers should be on welfare?" They received a resounding 90% "no" as their response.

After waiting a few months, they reframed the question to, "Do you think that women and children who have lost their husbands/fathers should receive help from the government?" They got a resounding 90% "yes." It is the same question, but the difference is that the second question is reframed so that it is linking back to positively held beliefs about basic issues like justice, fairness, and empathy. It is not making people think something different, it is just ties into a frame that they already have which makes sense to them.

With respect to next steps, NCIPC has plans to share this more broadly. They will ultimately have a unified, cohesive message for NCIPC. This will not be a campaign, but instead will be a part of all of their work. Their desire is that it becomes something that is more broadly used. When they get to the place of developing a dissemination plan, they hope to include something that will help people understand how to use it and embrace it as their own. The goal is to have that common message, that common one "ask." When NIH goes to the Hill they say, "Increase funding for cancer." It is one very simple message. They do not say, "Give us money for prostate cancer," and then go back to say, "Give us money for breast cancer," and then later say, "What about some leukemia money?" This one message has been extremely effective for NIH, which is partly what NCIPC is hoping for.

Discussion Points:

Dr. Tate wondered whether people with disabilities are represented among the partners, and she suggested Centers for Independent Living as a resource.

Ms. Tarkington responded that she was not sure whether they had specific disabilities represented. Given limited funding, they had to be strategic. One strategy was to choose people with as broad a cross-cutting background as possible. They are open to further input.

While there was a logic model behind this process, it was not clear to **Dr. Heinemann** at what point the planning process began. For example, did it begin at the programmatic level or division level? Was it project-specific and then expanded and grew to encompass other projects?

Ms. Tarkington responded that there was terrific synergy. They began many communication activities before they had clarity about efforts that were happening within the agency as a whole. Now they are matching up not only in that sense, but also with the center. The efforts definitely align with the center's logic model. With respect to the planning process, their contractor is writing a report from the meeting a couple of weeks ago, which will go back out to participants for review. They will then open it up to more partners who can give NCIPC feedback regarding whether this tool would be appropriate in their organizations and with their constituents, or if they even consider it to be an appropriate tool that would be useful for the field in general. They plan to go to message testing toward late February to early March. All along the way they do want feedback and there will be opportunities for that.

Dr. Heinemann asked Ms. Tarkington to expand on the message testing component, the size of the group targeted, and how they are recruited.

Ms. Tarkington replied that they have such a small contract, the size of the target group is extremely small as well. They plan to conduct some mini focus groups with the three target audiences after they develop a profile, and they plan to engage in some one-on-one interviews.

Because the public audience is multi-faceted and multi-cultural, **Dr. Sheryl Heron** asked Ms. Tarkington to speak to the cultural and literacy nuances that would need to be incorporated to get the messages of communication across.

Ms. Tarkington replied that there was discussion about Health Literacy and the Cultural Literacy that is a piece of that. Cultural/literacy issues will certainly be a part of whatever they create. There was discussion about the importance of this in the meeting as well.

Dr. Weiss called attention to the issue of victims and how to use victims in the framing. They have been talking about this for years in the field, but it is not clear they do this right and use victims in the best way possible. He wondered if this was discussed during the meeting. He encouraged NCIPC to seek input from an associated group—those who treat victims.

Ms. Tarkington replied that this was an issue they were attempting to figure out before the meeting, given concerns that there could be a dichotomy in the meeting. However, that did not occur. They achieved consensus. While they may not have come up with *the* message, simply engaging in a framing exercise highlights the fact that in addition to “injury” they have to use words like “hurt” or “harm,” which had more of a global appeal for people in the room. Having representatives coming from that perspective helped them to understand better what would and would not work. She welcomed the ACIPC participants to submit their feedback for all groups from whom NCIPC should be seeking input.

Dr. Winston pointed out that with any communication strategy, timing is important and they could save a lot of money if they are ready with their messages when a research paper or a new report from CDC is coming out—that is news. If the timing is right, the media will pay for it. Another mechanism is a webinar to tell the “army of educators” what they will soon hear in the news, although they must be careful about embargos. The outreach materials should already be prepared so that they can be part of a package on the website. A video news release would allow them to control their message. Children’s Hospital of Philadelphia recently had a press conference and for an addition \$6,000 they had a simultaneous webcast. This worked extremely well. She expressed concern with the process in that NCIPC appears to talk to themselves; that is, they brought like-minded people into the room, which is not the best way to conduct a focus group. That is, when public health people talk to public health people, they get public health advice, which in many ways has not been effective. She challenged NCIPC to seek feedback from those who have not been traditionally involved.

Ms. Tarkington replied that they do plan to open the discussion beyond the group in the meeting. They were chosen because they are cross-cutting. Others were not chosen because they could likely be the next place NCIPC goes to conduct focus groups, interviews, or other

information collection. They are aware that they need to include all arenas and it is part of the process to find them.

Dr. Winston stressed that a key part they often miss in public health messaging is the fact that the main target audience is the families with whom they want to make a difference, and it is the influencers of those families who must be in the room. Dr. Fowler requested that ACIPC members who agreed that communication work should be a priority raise their hands; 15 individuals at the table raised their hands in agreement.

Dr. Grossman said he was not entirely clear about the goal of the communication plan with respect to whether it was a branding effort so that NCIPC would become known as the purveyor of scientifically based injury messaging and research, or if it was really about social marketing to change behavior. Part of his confusion was derived from the list of target audiences; that is, he thought it would be a daunting task to brand themselves to the public, but less so to Congress.

Ms. Tarkington responded that they are trying to have one unified message so that there is evidence-based, strategic prioritized communication and that this fits in with the larger intentions of the center and with CDC's goals for a cascading effect. The other reason for having a strong, unified message, especially in an age of information overload, is to keep it from getting lost.

Dr. Arias pointed out that communications efforts, how people think about injuries, how concepts resonate differently based on cultural issues, etc., were underway several years ago. Some of that information was used in some of their materials, although some of it did not continue. At the injury conference in Denver, when people were asking why the media seems not to pay attention to injury, the plenary speaker told them that it was because they were all over the place and needed to develop a positive, single message that would let media know what they want. Dr. Arias closed out that session by committing the center to focus on that issue, and that she would deliver what that potentially unifying message should be at the next conference. Although the conference did not take place, the work Ms. Tarkington described is a continuation of that process. It is not necessarily to advocate or market solely for the center. Everyone in this field needs resources and they must figure out ways to move their target audiences to recognize the issue, do something about it, and garner resources devoted to it. This is a priority for the center already because it is the bedrock for everything else that they want to accomplish. If they do not get this straight, many other efforts will be limited.

Dr. Grossman asked how they planned to evaluate their success in this effort.

Ms. Tarkington responded that they have not defined the evaluation plan, but she thought that it would link back to the ultimate outcome—a reduction in morbidity, mortality, and disability related to injury.

Ms. Weiss stressed that they must know their outcomes at the beginning, given that it is very difficult to evaluate something after it has already gotten started. She agreed that they need a unified message, but pointed out that even when they have a message, people do not listen. For example, they have been very good at getting the message out about car seats; however, putting a

child in a car seat is the last thing people think about who live in poverty-stricken, disorganized neighborhoods.

Ms. Moyer pointed out that everyone involved with this work has a duty to carry the message forth; it is not just up to the center.

While she agreed that NCIPC should invest some of their budget in communication efforts, **Dr. Fowler** cautioned that if they create a need they cannot fill, they are liable to generate a level of mistrust and disappointment that could take 20 years to correct. Making NCIPC the “go to” place for injury control is not feasible with this budget. They could put themselves at great risk because they will be held accountable to do everything they promise, which is not reasonable with their current budget.

Dr. Redfern stressed that it is a “Catch 22.” If they do not communicate effectively, they will not get funds. Therefore, he applauded the idea of taking the risk and then asking for more money based on performance.

Dr. Fowler agreed, but pointed out that there are ways to combine messages as was done with all of the tobacco advocacy work. They were doing basic, good quality health education, but at the same time were building social will for national level action. NCIPC must consider what they actually want people to do at the end of it, and then they should keep their eye on that. The message can still be simple but still get them both.

With respect to behavior and behavior change, **Dr. Winston** reminded everyone that it is a specific action, taken by specific people, under specific conditions. There is no reason to communicate unless there is a sense of the answer to those three questions. The questions should be defined and then the messages developed. The message will differ depending upon whether it is the head of a health care plan, a person living in a community, a legislator—they all have to hear it in a way that makes sense to them. Moreover, they must have in mind what they expect to accomplish from all of this: What is the next thing you want them to say? You have to tell them why they should care about it, motivate them to move to action, and tell them what they should do, which is the part that seems to be missing.

Ms. Bill indicated that the Navajo have barriers in translating Navajo to English. For example, the word “injury prevention” is not in their language. Her message to NCIPC was that even at the community level, “injury prevention” is just a word that sometimes does not exist in communities. She also stressed that some communities perceive CDC as “those researchers coming into the community to do more research.” In order to change that perception and get messages across, CDC must also change their image of simply wanting to study people.

In summary, **Dr. Fowler** acknowledged that there was widespread concern about the limitation of the one focus group, the limited representation of partners, funding limitations, and barriers to access. However, each person around the table has direct communication with key informants or key stakeholder groups. Moreover, they have a model resource in Dr. Weiss and Pittsburgh where they have been conducting webinars, conference calls, etc., at a relatively low cost. Perhaps consideration could be given to convening some sort of stakeholder web meeting.

Group Discussion and Synthesis

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To initiate group discussion about what ACIPC can do to help NCIPC advance its partnership and communications activities, **Ms. Harris** posted the following discussion questions:

- What feedback do you have regarding our partnership engagement activities?
- How can ACIPC help advance CDC's activities and the activities of the field related to these priority areas?
- What barriers exist for ACIPC? How can these be overcome?
- How can we better leverage the assets you identified?
- What is the "ask" for child maltreatment prevention, residential fire-related injury prevention and fall prevention?
- How do we generate consensus in the field on these or on other "asks?"

She stressed that ACIPC is a partner that fits within the logic model Dr. Arias showed the previous day. In regard to the second question, "How can ACIPC help advance CDC's activities and the activities of the field related to these priority areas?" she said she was seeking concrete suggestions, ideas, activities, and ways that ACIPC as a group and as individual members could provide access to other organizations in order to best move this forward and to leverage NCIPC's finite \$138 million budget.

The suggestions, divided by potential partners and potential activities, are included in the following tables:

Source	Potential Partners	Comments
Various	ACIPC	<p>Consideration must be given to how much of a message each ACIPC member can carry. It would seem odd for someone working in suicide prevention to speak to a Congressman about fire prevention, although a case could be made for child maltreatment because it can lead to suicide. If they want ACIPC to serve as a champion, perhaps they should think more strategically and individually about how to do that.</p> <p>ACIPC members can also serve as a quick response mechanism, given that they do not have as many issues regarding clearance, etc. Members can put together comments, statements, press releases, etc., to bring focus to this issue in the national media.</p> <p>The ACIPC members should write a letter to CDC stressing the importance of reinstating the injury conference.</p>
Li	American College of Sports Medicine (ACSM)	ACSM conducts a lot of research in injury.
H. Weiss	Advocates/Champions	Advocates and champions are needed in specific areas, which is a never ending job.
Heinemann	American Congress of Rehabilitation Medicine	Multi-disciplinary group of nurses, physicians, and allied health focused on research on brain, spinal, and burn injury; annual meeting, newsletter, access to key populations
Heinemann	American Psychological Association – Divisions 22 (rehabilitation), 40 (neuropsychology)	150,000+ member professional association with expertise in risk reduction, behavioral health, neuroscience substrate of behavior
Li	Chronic disease and other fields	Consideration should be given to working with Chronic disease. They have done a great deal of work with respect to physical activity to prevent obesity, much of which relates to injury. For example, the built environment: Is it safe to walk in neighborhoods? What are the risks for injury? The same concepts would apply for falls prevention as well. The idea is to go beyond the field of injury prevention to incorporate some other fields.
Moyer, B. Weiss, Grossman, Adkins	Corporate/Private Partners (example: PATH with Gates funding)	<p>Denny's (Florida has engaged them), Verizon (have been involved in IPV and DPV), home builders/contractors, real estate agents, purveyors of fire/smoke alarm products (could provide services and realize PR in a way they perhaps have not considered: (Rayovac, Energizer, etc.)</p> <p>Biomechanics/automotive manufacturers—not only can companies make contributions of some sort, many of them are customers for the work that NCIPC does; that is, they are eager for the information generated and if they are solicited for input, the turnaround and translation time for improvements in this field in terms of lives saved is very rapid. For example, PATH in Seattle has leveraged funds from Gates Foundation to work with pharmaceutical manufacturers to create private partnerships so that the purpose of the PATH is to bring together the customer and the purchaser so they can create synergy there to move questions forward.</p>

	Corporate/Private Partners continued (example: PATH with Gates funding)	Who are the people who care about NCIPC's research? Bring them more deeply involved in the process, perhaps facilitated through the National Safety Council as a key conduit. Home Safety Council has worked with many corporations and could perhaps go back to them on this issue. Set up technology for repository or feedback of some sort to reach frontline folks They have a quality awards dinner every year; 20 to 24 people are on the stage to receive an award for some innovation that furthered safety through products and the distribution and communication of the value of those products to their consuming audience, which is obviously their own objective, but which also has a broader set of objectives that affects those in the ACIPC meeting room. The Home Safety Council Expert Network is a group of about 4,000 members to whom the Home Safety Council periodically sends out emails and questions them about issues. This is an opportunity to get injury questions out through this network. Home Safety Council also holds webinars.
Dawson O'Connell, Adkins	Community-based Groups Home Safety Council and Home Safety Council Expert Network	
Heinemann, Winston, Dawson, Grossman	Insurers: State Farm, American Founders Life Insurance Company (AFLIC), AARP, America's Health Insurance Plans, Alliance of Community Health Plans (ACHP)	State Farm has talked with NCIPC before, but left feeling like it did not work. They were very excited about working with NCIPC on a different topic, but it became so bureaucratic and difficult they left the table. However, there are many other insurance connections. NCIPC has had some preliminary conversations with AARP, who came to their fall prevention meeting in October. Chronic Disease has had success with AARP and injury is talking to Chronic about this. AARP has traditionally been a difficult organization to break into. Consideration should be given to CDC grantees who have ties with AARP at the state level. They do want and need help, but it may take a different avenue. America's Health Insurance Plans (the trade association for almost all insurance plans in the U.S.) and ACHP have pretty active prevention groups and have employees who focus on prevention. Dr. Winston may be able to help with State Farm; Billie Weiss may be able to help with AFLIC through the California Coalition. Dr. Grossman offered to connect NCIPC to both America's Health Insurance Plans and ACHP.

Heinemann	Interagency Committee on Disability Research	To the extent that injury is a part of disability, this is a wonderful liaison; CDC as a larger entity is represented
Grossman	National Committee on Quality Assurance (NCQA)/Centers for Medicare & Medicaid Services (CMS)/U.S. Preventive Services Task Force (USPSTF) under the Agency for Healthcare Research and Quality (AHRQ)	<p>Get accreditation measures imbedded. It gets the attention of a medical care organization or health plan than to have a set of standards, and also conveys a message that injury is part of prevention, so this would elevate the awareness of injury control.</p> <p>USPSTF is an independent organization that has become the leader in terms of performance assessments for health plans (Purchasers Guide to Healthcare Clinical Preventive Services is a binder for employers about what works in prevention, and is based very much on USPSTF guidelines). To the extent that U.S. Preventive Services Task Force (USPSTF) solicits comments and asks for suggestions for reviews, this is an opportunity for the injury community to weigh in; to the extent that they have more evidence around the efficacy of certain intervention, the more USPSTF guidelines there will be that will recommend those services. NCIPC can have direct contact with USPSTF and should look at what gaps and areas this Task Force has identified for which there is insufficient evidence because they will revisit them over and over to determine whether there is new evidence.</p>
Heinemann	National Institute on Disability and Rehabilitation Research	Single center focused on knowledge translation and dissemination; funds knowledge translation centers tied to their model systems for brain, spinal, burn injury; almost no cost effort there; Dr. Heinemann will provide specifics on grantee who has the Knowledge Translation Center
B. Weiss	National Institutes of Mental Health	Many of the behaviors they are discussing have relevance to mental health
O'Connell, Grossman	National Safety Council	Has 53,000 members, most of which are various sizes of corporations; every year they give a competitive prize to corporations that build a business case of success on how safety and injury control and prevention has affected their bottom line.
Grossman, Dawson, H. Weiss	Private Foundations: Robert Woods Johnson (RWJ), Gates, Annie E. Casey Foundation, Marcus Institute	<p>Who are the people who care about NCIPC's research? Get them more deeply involved in the process, perhaps facilitated through the National Safety Council as a key conduit. This would be a way to generate more interest, excitement, and recognition of CDC.</p> <p>RWJ has worked very closely with the Center for Chronic Disease.</p> <p>Annie E. Casey Foundation has done a lot of work around child maltreatment.</p> <p>RWJ has recently reprioritized and narrowed down their focuses and, for the most part, injury is not there.</p> <p>Gates is increasing the breadth of their vision, but access would take a well planned effort that includes the director and the whole CDC endorsement. CDC carries a lot of weight at Gates and has engaged in many partnerships there. Of the three focus areas,</p>

	Private Foundations continued: Robert Woods Johnson (RWJ), Gates, Annie E. Casey Foundation, Marcus Institute	fire might have the greatest potential appeal because it involves technology, it is a huge killer, and it is a quick fix because they know what to do. ACIPC could help in this area. Sue Gallagher has worked really hard to get Gates to think about injury and she has contacts there. Dr. Grossman also has a number of contacts there and will make an effort as well.
Adkins	Pro Literacy Worldwide	The Marcus Institute (Bernie Marcus from Home Depot) is a local foundation and they have a connection there with John Lutzker around child maltreatment. The Home Safety Council has used this resource in crafting their fire message for people who have low literacy or for whom English is not their first language. The Home Safety Council can probably be very helpful with this connection because they have a solid relationship.
Hardman	Public Health Information Officers	All state health departments have Information Officers and a group of people who work with them—frequently, injury folks are down the “food chain” and don’t have direct access to them, so it can be difficult to educate them about priority/focus areas; if CDC could help them realize the injury programs are there and the focus, this would be a good use of time
Reed	Research America	Perhaps it is time for a national poll about what Americans think about injury. A one-page paper can be developed based on that poll data similar to ones they have done on other health concerns that go to every member of Congress and the media. This is a very good way to raise the profile of injury that is not terribly costly.
Heinemann	Retirement Research Foundation	This organization focuses on healthy living in older years. Their grants are small, but they may be able to do some things that AARP is less interested in. Dr. Heinemann has worked with them. They are in the Chicago area.
Wilcox	SafeKids	SafeKids have coalitions across the country and in other countries, as well as many experts who are actually on the ground doing injury prevention. SafeKids can send emails and other communications to obtain feedback, input, and involvement. They use many of their coalition coordinators to help them craft low literacy messages and produce documents.
B. Weiss	Substance Abuse and Mental Health Services Administration	Many of the behaviors they are discussing have relevance to mental health
Fowler	World Health Organization (WHO)	This year or next, WHO will be releasing its report on childhood injury. This is all over the WHO and UNICEF websites, and they should be ready to jump on this opportunity.

Source	Potential Activities	Comments
Fowler, B. Weiss, Redfern	Audit NCIPC's work	Consider preparing an audit of NCIPC's funds with respect to where these funds have gone, what has happened in America because of this work, and how many lives have been saved because of that. All of the Injury Centers, Centers of Academic Excellence, and state programs should be auditing themselves to get a sense of what they have done. There are success stories to sell. Dr. Redfern pointed out that the portfolio reviews are doing exactly this, although there are some other things they can do with the centers.
Bill	Attend CDC-wide goal setting meetings	ACIPC members should attend some of these to carry the message of what they are concerned about into the taxonomy of the goals that have been configured for the CDC-wide enterprise. Injury keeps ranking 39 out of 45 items at roundtables of 10, so it may be a matter of getting "boots on the ground" there to represent NCIPC's interests.
Various Fowler, Winston, Grossman	Convene a stakeholder web meeting Electronic medical record triggers/referrals	This is a potential resource for collecting a broader range of input. Children's Hospital Philadelphia uses an electronic medical record with instant referrals if questions are answered in certain ways. For example, if a child has not had a particular vaccine, this triggers an immediate referral. Consider how to get instant triggers into medical records so that if someone says they smoke, it automatically triggers a referral to cessation as well as fire prevention. However, this is a complicated question which gets into the actual clinical worksite. In an effort to make clinical life simpler for physicians, this could be difficult, but there are ways to reach patients directly without having to get the clinical team involved, for example with health risk appraisals. What prompts those questions is key, which is a reason for imbedding themselves in the quality process.
Reed	Hill Briefing	Consideration should be given to organizing a Hill briefing for staffers on the cost of injury. Perhaps the members of ACIPC who are very versed in different areas could help. If ACIPC all went to their connections, they could say suicide is part of injury. Rape is part of injury. People do not always make those connections.
H. Weiss	History of NCIPC	NCIPC began with zero, then received \$10 million, and has come a long way since then to reach \$138 million. Perhaps it would be beneficial to review that history to determine how they got there in order to think about how to move forward. Consideration should be given to how much of that came from outside, mandated by Congress, and how much was from getting things accepted internally.
Reed	Injury meeting	A major issue is the lack of resources to bring people together every couple of years. Consideration should be given to getting back the resources to convene a national conference where people can meet face-to-face. If not in person, at least get them together on short webinars or virtual meetings to keep this community building. The loss of the conference is a tremendous loss to the field. They should not be satisfied with that loss. Perhaps this is one of the internal "asks." All other fields this large, with this much of an impact on the healthcare system, have national meetings.

O'Connell	Inventory existing channels with whom you already have relationships or intervening relationships	NCIPC has existing relationships with various groups who have extensive relationships with others and must do a better job of sharing the resources with those who already sit with them (Home Safety Council, National Safety Council, others).
Reed, Dawson, Winston	Reframe public health's mission, reframe injury messages, sound bites	Public health addresses rape and inspecting septic tanks for example. Reframe people's thought process about public health by developing a few sentences about public health's mission and how injury fits into that. In the communications efforts, NCIPC should align it in the context of the greater public health message. Also, injury is a hard sell. It is not clear that they have done a good job convincing the public that injury is something that can touch them and that it is a public health issue. It is really seen more as a private issue, as accidents and individual failures. What changed the nation's response to the prevention of suicide was that it was presented as a public health problem with 32,000 deaths and not an individual problem of one loss of life. NICPC must frame how many TBIs, fires, lives lost, etc., there are each year to preventable injuries to help make the leap from the individual to the public.
Fowler	Seek information from other countries	While other countries are different in various ways, there is a wealth of international advocacy wisdom from which they should be learning. For example, how did Australia get to the place where they understood that they had to build safer traffic environments?
Dawson	Set up technology for repository or feedback of some sort to reach frontline folks	For example, in addition to a state health departments having contact with their State Health Director and ASTHO, also being able to send an email to Safe Kids Coalitions to direct them to CDC's website looking at how to frame injury and the message so they can have frontline input.
Moyer	Spread the word via ACIPC members	Everyone on this committee should take every opportunity to identify themselves as someone who works on ACIPC, and speak about the three priorities.
Grossman	Standards and performance processes for healthcare performance should be embedded for injury	For example, get in a set of prevention measures that are promoted as quality measures by the National Committee on Quality Assurance that are used as accreditation measures for health plans; there's no better way to get the attention of a medical care organization or health plan than to have a set of standards, and also to convey a message that injury is part of prevention—this would elevate the awareness of injury control.
Grossman	Submit comments to other groups	To the extent that U.S. Preventive Services Task Force (USPSTF) solicits comments and asks for suggestions for reviews, this is an opportunity for the injury community to weigh in; to the extent that they have more evidence around the efficacy of certain interventions, the more USPSTF guidelines there will be that will recommend those services.
Wilcox (personal comment), B. Weiss	Training of public health officials	There is an early movement around the idea of credentialing public health workers and accrediting state and county public health departments. There may be an opportunity here to get involved with that and ensure that injury prevention is a key component of those accreditation and credentialing final standards and processes. Another gap in training is that injury is not integrated into a lot of the public health schools, and there are people working in public health departments who are not injury people, but are working in injury. There are some training initiatives in place that could perhaps be reactivated in order to implement training and integrate the messaging as well.

Discussion Points:

Dr. Grossman inquired as to what the boundaries are for members of ACIPC with respect to contacting legislators.

There may be some boundaries with respect to contacting legislators, so **Ms. Harris** indicated that she will check with CDC's Ethics Committee for clarification.

Dr. Fowler inquired as to how ACIPC could help facilitate getting back the national injury meeting.

Ms. Harris responded that they could convey this to NCIPC representatives, who would carry it forward.

Motion

Mr. Reed motioned for the minutes to reflect that ACIPC supports the reinstatement of a national gathering of the injury community. Ms. Weiss seconded the motion, which carried unanimously with no abstentions.

With respect to the advisory structure, **Dr. Fowler** inquired as to whether there was anything ACIPC could do to help internally, such as a letter, to support NCIPC as they go through the goals process and the reorganization.

Dr. Arias replied that there are two levels of support. One is giving feedback during ACIPC meetings, and their commitment and identification of things ACIPC members can do, which needs to be maintained. More formally, there are some limits. The suggestion about getting as involved as possible in the vetting of the goals and then raising the issue of the importance of injury and violence being included in those plans is critical, and is probably one of the most important things ACIPC members can do. It has been very clear for the last 2 or 3 years that the goal structure is here to stay, and it is starting to inform how everything is done and how everything is being organized at the agency. Research will also be organized along those lines as well. The focus so far has been on actual programs that can be done; however, there is the research guide and there is some activity starting in turning it into a research agenda and it is going to follow that structure of goals. NCIPC staff members are working hard to make sure injury is included, but having that happen from the outside is critical so that it is not perceived as NCIPC merely trying to justify their existence—instead it is seen as addressing a significant national need. If they cannot participate personally, comments of support for the inclusion of injury can be sent to the director of the coordinating center, Dr. Falk, who is also chair of the steering committee for the goals process at CDC.

Ms. Harris stressed that whenever ACIPC members experience a success, a concrete outcome, wherever they might be working, no matter how small or large it might seem, NCIPC can use that information. They can share this directly with Dr. Falk and Dr. Gerberding as well.

Dr. Winston suggested that it be added to grantees' contracts that they must provide this concrete evidence of outcomes/successes on a regular basis.

Motion

Ms. Weiss motioned for continued support of the training initiatives that have begun, or to ensure that there is some training of the public health and injury prevention workforce. Dr. Redfern seconded the motion. Further discussion ensued.

Dr. Redfern stressed that the reason this motion is important is because as budgets are tightened, training tends to be squeezed out. While short-term this does not affect anything, it is terrible for the long-term health of injury prevention research in this country.

Dr. Fowler inquired as to whether they would like to amend the motion to strongly emphasize the importance of protecting the future of the field.

Dr. Grossman requested clarification on the subtext. He wondered if there was a specific program or budget line that was in question.

Ms. Weiss responded that the context is that training is being cut, and is often the first thing to go in a climate of budget cuts. There must be a workforce coming behind older members of the field who can move into their places in the injury prevention field. There is imminent danger of losing some training entirely.

Dr. Winston suggested an amendment to state that "before cuts are made to training in the future, ACIPC wants to hear about it. If an emergency conference call is needed to discuss it, one should be convened."

Dr. Grossman suggested moving this topic to the agenda for the next meeting in order to give it the more in-depth consideration it deserves.

Dr. Arias responded that many of them at the center are researchers and were in academia before, so they recognize the importance of training. At the behest of CDC, at the center they have initiated discussions and examinations of succession planning issues, not only within in CDC in the Injury Center, but also the field as a whole. They all recognize that it is a problem about which something must be done. Decisions must be made about where cuts are going to be made, because they must be made somewhere. The people who are telling them to cut the budget have no preference for where cuts are made. NCIPC knows the issue, they are trying to work on it, and perhaps the issue would be best addressed as an agenda item for the next ACIPC meeting. NCIPC can begin looking within their coordinated center structure and CDC about possible alternatives to addressing the training issues without necessarily continuing some of the training programs that have been funded in the past if that is not feasible.

Motion

Ms. Weiss amended her motion to state that ACIPC wishes to further discuss the issue of training during the next meeting, and would like to hear at that time from the Center and CDC regarding where training issues are headed. Dr. Redfern seconded the motion, which carried unanimously with no abstentions.

With respect to training, **Dr. Weiss** suggested that on the agenda for the next ACIPC meeting they include presentations/discussions about what other bodies are doing to move training forward. For example, TRB is moving ahead with this and there is funding coming to focus on the traffic community with a partnership with public health. Tom Saunder can speak to that. NIJ may also be able to step in and be involved in this area. Clearly, CDC cannot do this alone.

Public Comment, Wrap Up, and Adjourn

Dr. Fowler opened the meeting for public comments; however, none were offered. In closing, she stressed the importance of the members communicating frequently with NCIPC, as well as offering their support in the form of telephone calls, letters, etc. She thanked the ACIPC members for their participation, as well as those who helped plan and organize the meeting. In addition, she thanked the contractor, audiovisual company, and writer/editor for their support services. She stressed that they have been receiving excellent minutes from these meetings due to the clarity of the reporting. Dr. Fowler also expressed gratitude to all of the NCIPC staff members and partners who attended the meeting and listened to what ACIPC members had to say.

Dr. Arias expressed her appreciation to the ACIPC members for their time and feedback, stressing that their comments do not go unheard. In order to make this meeting as productive as possible, and for members to see how NCIPC is responsive to ACIPC's suggestions, she requested that each member send an email to NCIPC to indicate, out of all the things they discussed during the meeting, what two or three issues NCIPC should provide follow-up on during the next meeting. This will assist NCIPC not only in setting the agenda, but also in identifying what is truly important with respect to how they need to focus their work.

With no further business posed, Dr. Fowler wished everyone safe travels, and officially adjourned the 48th meeting of ACIPC at 12:00 p.m.

Committee Members Present:

C. Hendricks Brown, Ph.D.
Carolyn J. Fowler, Ph.D., M.P.H.
Ralph F. Frankowski, Ph.D., M.P.H.
Nancy G. Guerra, Ed.D.
Allen W. Heinemann, Ph.D.
Sheryl L. Heron, M.D., M.P.H., F.A.C.E.P.
Chester Huber
Ivan J. Juzang
Fuhzong Li, Ph.D.
Diane E. Moyer, J.D.
Mark Redfern, Ph.D.
Jerry Reed, M.S.W.
Denise G. Tate, Ph.D., ABPP
Billie P. Weiss, M.P.H.
Flaura K. Winston, M.D., Ph.D.

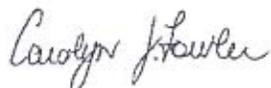
Amy Harris, M.P.A.
Sarah (Gail) Hayes
Michele Huitric
Richard Hunt, M.D., FACEP
Robin Ikeda, Ph.D.
Yvonne Jennings
Reneé Johnson, R.P.T., M.S.P.H.
Jean Langlois, Sc.D, M.P.H.
Leslie Lorenz
Karen Mack
Charles Magruder, M.D., M.P.H.
Angela Marr, M.P.H.
Diana Miles, Ph.D.
Daphne Moffett, Ph.D.
Chester Pogostin, D.M.V., M.P.A.
Bill Ramsey
Joe Russel, B.S.
Kelly Sarmiento, M.P.H.
Jessica Shisler
David Sleet, Ph.D.
Paul Smutz, Ph.D.
Amanda Tarkington
David Wallace. M.S.E.H.
Rick Waxweiler, Ph.D.

Others Present and Affiliations:

Patricia Adkins, Home Safety Council
Rob Blake, GA Division of Public Health
Jim Evans, Sound on Site (A/V Technician)
Andrea Barrett, Maximum Technology Corporation (Contractor)
Aurita Prince Caldwell, STIPDA
Bobby Jackson, NSC
Bill O'Connell, NSC
Shelli Stevens-Stidham, STIPDA
Stephanie Henry Wallace, Cambridge Communications & Training Institute (Writer/Editor)
Amber Williams, STIPDA
Elizabeth Wilson, NSC

Certification

I certify that, to the best of my knowledge, the foregoing summary is accurate and complete:



April 25, 2007

Dr. Carolyn Fowler, ACIPC Chair