

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
Centers for Disease Control and Prevention  
National Center for Injury Prevention and Control**

**Board of Scientific Counselors**



**Tenth Meeting  
October 18-19, 2012  
Summary Report**

## Table of Contents

Call to Order / Roll Call / Announcements / Meeting Logistics .....	3
Director’s Update.....	4
Science Update .....	10
Child Injury: The National Action Plan for Child Injury Prevention Phase II .....	10
Prescription Drug Overdose Prevention Strategies .....	14
Division of Violence Prevention Update .....	18
Division of Analysis, Research, and Practice Integration Update .....	20
Research to Practice Agenda .....	<b>Error! Bookmark not defined.</b>
Demonstration of the New BSC Secured Website .....	<b>Error! Bookmark not defined.</b>
Evidence and Dissemination .....	<b>Error! Bookmark not defined.</b>
Engaging Public Health Practitioners in the Policy Process .....	<b>Error! Bookmark not defined.</b>
Opening / Roll Call.....	<b>Error! Bookmark not defined.</b>
Global Activities at NCIPC .....	<b>Error! Bookmark not defined.</b>
20 <sup>th</sup> Anniversary Activities .....	<b>Error! Bookmark not defined.</b>
Communications: Where Are We Going? .....	<b>Error! Bookmark not defined.</b>
Incorporating more Practice Input to the BSC.....	<b>Error! Bookmark not defined.</b>
Public Comment Period .....	<b>Error! Bookmark not defined.</b>
Wrap-up, Roll Call, and Adjourn .....	<b>Error! Bookmark not defined.</b>
Attachment A: Meeting Participants .....	<b>Error! Bookmark not defined.</b>
Attachment B: Acronyms Used in this Document .....	60

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)  
NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL (NCIPC)**

**BOARD OF SCIENTIFIC COUNSELORS**

Tenth Meeting: October 18-19, 2012  
Chamblee Campus, Building 106, Conference Room 1B  
Atlanta, GA 30341

**Summary Proceedings**

The tenth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) took place on Thursday, October 18, and Friday, October 19, 2012. Dr. Carolyn Cumpsty Fowler served as chair.

**Thursday, October 18, 2012**

**Call to Order / Roll Call / Announcements / Meeting Logistics**

**Carolyn J. Cumpsty Fowler, PhD, MPH**  
**Chair, National Center for Injury Prevention and Control**  
**Board of Scientific Counselors**  
**Assistant Professor, Johns Hopkins University**  
**School of Nursing and Bloomberg School of Public Health**

**Dr. Fowler** called the 10<sup>th</sup> meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) meeting to order at 8:35 am on Thursday, October 18, 2012. She thanked the BSC members for their time and commitment to violence and injury prevention. She indicated that the meeting agenda included ample time for discussion, and encouraged BSC members to engage in an informal exchange of ideas, questions, and feedback.

**Mrs. Tonia Lindley**, Committee Management Specialist for NCIPC, conducted a roll call of BSC members present in person and via teleconference. A quorum of BSC members was determined to be present.

**BSC Members Present (In Person)**

- Carolyn Cumpsty Fowler, PhD, MPH, Assistant Professor, Johns Hopkins University School of Nursing and Bloomberg School of Public Health (Chair, BSC)
- Fuzhong Li, PhD, Senior Research Scientist, Oregon Research Institute
- Lourdes Linares, PhD, Associate Professor of Pediatrics and Psychiatry, Mount Sinai School of Medicine
- Maury Nation, PhD, Associate Professor, Department of Human and Organizational Development, Vanderbilt University

**BSC Members Present (Via Teleconference)**

- John G. Borkowski, PhD, Professor, Department of Psychology, University of Notre Dame
- David C. Grossman, MD, MPH, Director, Department of Preventive Care, Group Health Cooperative
- Deborah Prothrow-Stith, MD, Consultant, Spenser Stuart

### **Federal Liaisons Present (In Person)**

- Dawn Castillo, MPH, Director, Division of Safety Research, National Institute for Occupational Safety and Health (NIOSH)

### **Federal Liaisons Present (Via Teleconference)**

- Lisa J. Colpe, PhD, MPH, Chief, Office of Clinical and Population Epidemiology Research, Division of Sciences and Intervention Research, National Institute of Mental Health (NIMH)
- Mary Ann Danello, PhD, Associate Executive Director for Health Sciences, US Consumer Product Safety Commission (CPSC)
- Thomas E. Feucht, PhD, Executive Senior Science Advisor, National Institute of Justice (NIJ)
- Iris Mabry-Hernandez, MD, MPH, Medical Officer, Senior Advisory for Obesity Initiatives, Center for Primary Care, Prevention and Clinical Partnerships, Agency for Healthcare Research and Quality (AHRQ)
- Lyndon Joseph, PhD, Health Scientist Administrator, Division of Geriatrics and Clinical Gerontology, National Institute on Aging (NIA)
- Elizabeth A. Edgerton, MD, MPH, Branch Chief, EMSC and Injury Prevention, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA)

A list of additional meeting participants is provided with this document as Attachment A.

**Dr. Arlene Greenspan**, Associate Director for Science, NCIPC, greeted everyone and provided details regarding meeting logistics.



### **Director's Update**

**Linda C. Degutis, DrPH, MSN**  
**Director, National Center for Injury Prevention and Control (NCIPC)**  
**Centers for Disease Control and Prevention (CDC)**

**Dr. Degutis** welcomed the BSC and provided an update on activities and events at NCIPC. She reported that the United States (US) government will operate under a Continuing Resolution (CR) through March 2013. NCIPC's current funding level is the same as Fiscal Year (FY) 2012 at approximately \$137 million. The President's proposed budget and the House and Senate appropriations bills propose that funding for NCIPC remain at the FY 2012 level. In addition, the Prevention and Public Health Fund (PPHF) established by the Affordable Care Act (ACA) includes \$3 million for fall prevention to be administered by NCIPC.

NCIPC was recently reorganized in order to improve efficiency, to foster collaboration across the center, to align research in various areas, and to create opportunities to address cross-cutting issues. The reorganization decreased the size of the director's office by relocating staff

to the divisions. The divisions relocated some staff to branches. In the past, NCIPC was organized into three divisions: Division of Violence Prevention (DVP), Division of Unintentional Injury Prevention (DUIP), and Division of Injury Response (DIR). DVP was the only division with branches, while the other two divisions had teams. The reorganization process created a branch structure in each of the divisions.

The Office of the Director (OD) now includes the position of Senior Advisor for Global Affairs. The Extramural Research Program Office (ERPO) is now part of the Science Office under the Office of the Associate Director for Science (ADS). The former Health Communication Sciences Office is now the Office of Communication, and the former Office of Policy, Partnerships, and Evaluation is now the Office of Policy and Partnerships. The Office of Program Management and Operations is also housed in the OD, led by Bob Ruiz.

DVP still has three branches, but has changed some of its teams and decreased their size so that they are more manageable. DUIP still has the Transportation and Motor Vehicle Safety Team and the Home and Recreation Team, which are organized under the Home Recreation and Transportation Branch. The Heads Up Program, a well-known sports concussion program, is part of that branch. The Health Systems and Trauma Systems Branch includes the Prescription Drug Overdose Team. The branch also includes the Health Systems Team and Traumatic Brain Injury (TBI) Team, both formerly under DIR.

The new Division of Analysis, Research, and Practice Integration (DARPI) has two branches. The Statistics, Programming, and Economics Branch includes the former Office of Statistics and Programming, as well as statisticians from throughout NCIPC. The new Health Economics and Policy Research Team focuses on cross-cutting issues related to economics and policy research. The Practice Integration and Evaluation Branch includes the state Core Violence and Injury Prevention Program (Core VIPP) with the Violence and Injury Prevention Team and the Evaluation and Integration Team.

A number of staff members who were formerly in the OD Communications Office now work in the divisions in order to provide better support for communication at the division and branch levels. The sizes of the teams vary among the branches and divisions. The Prescription Drug Overdose Team is one of the smaller teams, with four or five people. Larger teams in DVP have eight to twelve people, depending upon their functions and workload. NCIPC has 265 full-time employees, with occasional fellows or contractors.

NCIPC has focused on partnerships to advance the field in resource-stressed times. The Office of Policy and Partnerships has developed a partnership strategy to drive the center's efforts. The strategy includes building partnerships with the private sector and building synergies with other federal agencies and centers within CDC. NCIPC works with other federal agencies on a number of broad initiatives regarding prescription drug overdoses. NCIPC has a significant role as they work with the Office of National Drug Control Policy (ONDCP), the Substance Abuse and Mental Health Services Administration (SAMHSA), the US Food and Drug Administration (FDA), the US Department of Veterans Affairs (VA), and other entities. Dr. Degutis expressed her hope that the BSC would discuss strategies for developing private partnerships.

## **Discussion Points**

**Ms. Sara Patterson** (Associate Director for Policy, NCIPC) pointed out that due to the broad range of its activities, NCIPC has historically struggled with partnerships. The center's partnership strategy will help them engage with partners to further NCIPC's goals and the field's goals. In some cases, a partnership may not be appropriate, but a networking relationship and information-sharing may be more effective. The strategy focuses on moving forward with partners within the public health model. Given the current funding scenario, it is critical to leverage private resources. She asked the BSC for feedback on strategic partnership-building, sectors, and / or organizations that might be active in areas that share interests with NCIPC.

**Dr. Fowler** asked how the partnership strategy was created, whether it was created with specific ends in mind, and whether the desired partnerships will focus solely on the national level or will also work with core infrastructure at the state level.

**Ms. Patterson** answered that the overarching strategy focuses on potential partnership sectors and how to engage partners in various ways. The center is developing priority strategies for each of its focus areas, which will help determine the steps that will lead to the ultimate goals of reducing violence and injuries. For example, in the prescription drug arena, strategies address Prescription Drug Monitoring Programs (PDMPs), Patient Review and Restriction (PRR) Programs, and guideline development. The center considers potential partners for each strategy and the "levers to pull" for high impact. The center is also open to opportunities that may not align with their specific strategies, as well as new ideas. Infrastructure at the state level is a major concern for the center, with the Core VIPPs and the Injury Control Research Centers (ICRCs). It is important to build the field with practitioners and researchers. With the loss of eight Core VIPP programs and six motor vehicle grantees this year, dwindling infrastructure is a major concern for NCIPC, the National Association of County and City Health Officials (NACCHO), and the Association of State and Territorial Health Officials (ASTHO). Ms. Patterson observed Congressional interest in the recent cuts and infrastructure challenges, but it can be challenging to identify partners to help promote infrastructure. NCIPC addresses many topic areas, and it is difficult to unify partners with one message. Safe States Alliance has developed a network of partners that discuss strategies.

**Dr. Li** asked about international partnerships that can offer more resources for NCIPC's global work.

**Ms. Patterson** responded that partnerships drive NCIPC's global efforts, given that the appropriation structure does not authorize the center to apply appropriated dollars to global work. All of NCIPC's global work is funded by CDC's Center for Global Health (CGH), foundations, or private industry. For instance, a number of groups support the Together for Girls Initiative, including United Nations (UN) agencies and private sector companies. Other entities, including CDC's Global AIDS Program and the United States Agency for International Development (USAID), are interested in this work and in violence against children. NCIPC's global strategy will focus on partnerships and key activities. Center staff members have met with multiple visitors from multiple countries in recent months, and they hope to harness the international interest in injury issues.

**Dr. Greenspan** pointed out that the meeting agenda included additional discussion on global issues. NCIPC is considering its global interests and priorities. Originally, the OADS coordinated the center's global work. With increased interest and changes in funding streams, a senior advisor is coordinating the center's global activities and the development of partnerships and funding streams.

**Dr. Feucht** commented that NIJ has been grateful for its collaborative experiences with NCIPC. The NIJ Office of General Counsel is completing new regulations regarding public-private partnerships. He offered to share the regulations with NCIPC when they are released. Partnerships with philanthropic foundations can be challenging. Demonstrations or field experiments can lend themselves well to the focus of foundations, which have strong advocacy roles and may not focus on evidence. In this scenario, private foundations could provide implementation of programs and could support technical assistance, while the federal role could focus on science, research, and evaluation.

**Ms. Patterson** expressed her interest in the NIJ's guidance and in engaging with philanthropic organizations.

**Dr. Grossman** noted that CDC's work in injury is not well-known in the health sector. There are opportunities to raise NCIPC's visibility in certain areas, especially in falls prevention, where there is strong interest in the health sector.

**Dr. Degutis** asked about opportunities for partnerships and for educating the healthcare sector regarding Accountable Care Organizations (ACOs) and other provisions of the ACA.

**Dr. Grossman** responded that he is involved in ACO work in his institution and state. Because of ACOs, the health sector is increasingly interested in public health and the need to keep populations healthy. There may be opportunities for NCIPC in the future, but the ACO development is at a formative stage and is not necessarily focused on issues of sharing responsibility among partners or on financial arrangements. For years, Health Maintenance Organizations (HMOs) such as Kaiser have been more interested in injury prevention than health systems have. Trauma centers have had some interest in injury prevention, but have not had a strong reach into other systems. ACOs could provide that opportunity. The Centers for Medicare and Medicaid Services (CMS) is running a program of Pioneer ACOs, and this small group could be an opportunity for interaction.

**Dr. Fowler** asked whether all of NCIPC's partnerships will support the center and its mission, or whether the center is interested in relationships that can accomplish the work of injury through other partners.

**Ms. Patterson** replied that NCIPC wants to advance its mission and vision, but it is also important to build capacity and move the overall field forward. For example, NCIPC's work in guideline development includes standardizing guidelines, identifying best practices, utilizing best practices, and assuring adherence to guidelines. A number of guidelines are in the field, but it is not clear whether practitioners follow them and / or whether they are effective. NCIPC funded the American College of Emergency Physicians (ACEP) to create guidelines regarding emergency department prescription of opioids. This effort is an example of how NCIPC works with organizations and entities that have common interests to support and enhance their work and to build the evidence base as the organizations and entities work with their communities to disseminate and implement needed initiatives.

**Dr. Linares** expressed her happiness that child maltreatment is one of NCIPC's goals. Most hospitals have child protection teams that focus on children's issues, and she wondered about the possibility of partnering with those teams.

**Dr. Howard Spivak** (Director, DVP, NCIPC) answered that the center has worked in this area but needs to expand its efforts. They hope to link their work on surveillance of violent deaths with child fatality datasets. A new initiative called *Essentials for Childhood* represents a broad effort which includes the healthcare community. The implementation process for the initiative will require partnerships.

**Ms. Patterson** added that the center is conducting evaluations of shaken baby and abusive head trauma programs in two states. Those evaluations and settings present opportunities for partnerships. *Essentials for Childhood* is a useful resource that addresses strategies for communities to consider, such as data collection and programs to implement based on the data. The resource includes policy and program strategies and can be used by different types of partners in multiple sectors.

**Dr. Linares** envisioned disseminating the information in waiting rooms of hospitals. **Ms. Patterson** noted that the center recently met with the American Medical Association (AMA) regarding developing videos on safety or parenting that could be played in waiting rooms.

**Dr. Fowler** asked about NCIPC's partnerships with professional organizations such as the American Academy of Pediatrics (AAP) and the National Association of Medical Examiners (NAME). She also wondered about partnering to advance evidence-based practice. These partners are very helpful for disseminating information, but it is also important to change the way that practitioners such as pediatricians and medical examiners think about injury and the way that they are connected to injury issues.

**Ms. Patterson** agreed, noting that she had met with the ACEP in the Trauma and Injury Section of their annual conference. They identified specific projects for potential collaboration, building on past partnerships such as the Terrorism Injuries Information, Dissemination, and Exchange (TIIDE) initiative. Their conversations often begin with the topics of education and information dissemination. Many national organizations view themselves as distribution channels to their members. ACEP also discussed how they can work with the National Action Plan (NAP) for Child Injury by developing 10 actions they can take to implement the plan. The ideas were specific and focused on how to change practice and how to affect policy. NCIPC also worked with AAP to develop steps that pediatricians can take to implement the NAP and how to tailor the *Essentials for Childhood* guide for pediatricians.

**Dr. Fowler** asked whether NCIPC works with the Association of American Medical Colleges (AAMC). **Dr. Degutis** replied that broader efforts at CDC are focusing on AAMC. A partnership workgroup at the CDC senior leadership level is assessing strategies for engaging and working with various partners.

**Dr. Nation** observed that NCIPC is in an exciting position and is able to think forward. It would be helpful for the BSC to learn about the center's strategies and priorities in partnership development. Partnerships are important not only in terms of accomplishing the center's goals, but also to raise the profile of the center.

**Ms. Patterson** said that the center would share the priority and partner strategies with the BSC when they are complete. She agreed with the need to utilize partnerships to raise the profile of NCIPC. It is important to illustrate how the center can complement the work of other sectors, such as the healthcare sector, and how the center can support them as they work in tandem to reach mutual goals. The center needs an overarching, cross-cutting strategy, and the BSC's input will be very valuable.

**Dr. Li** recognized that NCIPC includes divisions and branches with many goals and objectives. He asked about the center's overarching goals as well as its short- and long-term goals.

**Ms. Patterson** said that the partnership and priority strategies are tied to metrics that the center developed. The BSC can review those goals and how they fit together.

**Dr. Fowler** encouraged Ms. Patterson not to wait until the next BSC meeting to share these materials and acquire feedback, but to utilize the secure BSC website strategically to move forward more quickly. She then turned to the issue of cuts to state programs and concerns about infrastructure, asking whether the cuts are a one-time tragedy.

**Ms. Patterson** replied that the cut to the Core VIPP was a one-time situation because the funds were identified last year, but were not available this year. US government sequestration is projected to be an 8% cut across all budget lines and could affect every federal agency. The economic situation is uncertain, so NCIPC continues to monitor the congressional process and to pursue leveraging private partnerships to complement their appropriated funds. A potential strategic direction is toward evidence-based policy strategies that can be implemented in multiple settings.

**Dr. Grossman** addressed opportunities to determine where injury prevention belongs in the essential health benefits outlined in the ACA. These issues are a concern at the state level as states create their health insurance exchanges (HIEs). Health plans are not aware of some of the cost-effectiveness of injury prevention interventions and devices. He suggested that NCIPC explore this issue and the extent to which benefit packages are offered through the exchanges.

**Dr. Borkowski** commented on the problem of passing the wisdom of people within NCIPC to others who are forming partnerships. He wondered about a system for consulting or providing advice to leaders in the partnership formation role. Without sharing past expertise on partnership successes and failures, they could be in danger of duplicative efforts.

**Ms. Patterson** agreed that NCIPC struggles to avoid having the same conversations with partners, but in different parts of the organization. They are building a database of the thousands of organizations with which they maintain contact. They can cull that list down to a few groups and capture "lessons learned" information systematically so that they are not relying on people or happenstance to inform their partnership outreach efforts. NCIPC will build on DVP's work in this area. She agreed that it is important to engage with the field as they create their partnership outreach strategy.

**Dr. Nation** asked how NCIPC is engaged with HIE directors as they develop their plans, pointing out that now is the time to engage with them. **Ms. Patterson** answered that CDC is involved in this work.

**Dr. Lee Annest** (Director, Office of Statistics and Programming, NCIPC) said that his office has been engaged in how to use injury data in the electronic health record (EHR) system. They hope to include cause of injury coding in the system. External cause codes are one of the core data elements for syndromic surveillance. Those data will flow from hospitals to state health departments and then to CDC. A significant issue regards whether the data will be coded early enough for syndromic surveillance.

With no further discussion posed, **Dr. Fowler** ended the session and dismissed the group for a break at 9:51 am. Upon reconvening at 10:08 am, **Dr. Fowler** called the roll to establish that a quorum had been maintained.

## Science Update

### Overview

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

**Dr. Greenspan** indicated that the format of the science update for this meeting would differ from the format utilized in past meetings. The BSC received handouts on each division's scientific work, so that the meeting could focus heavily on discussion and feedback. She noted that the OADS works with the center's evaluation scientists on portfolio reviews. The communication portfolio review is underway and represents NCIPC's first attempt at a crosscutting portfolio review. The center is learning from the review's challenges in working with all of its divisions and with the contract. The process has been delayed, but they are collecting data and expect to report findings at the next BSC meeting.

### Child Injury: The National Action Plan for Child Injury Prevention Phase II

**Grant Baldwin, PhD, MPH**  
**Director, Division of Unintentional Injury Prevention**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Baldwin** explained that the *National Action Plan for Child Injury Prevention* was released on April 16, 2012 and coincided with a *Vital Signs* release on 10-year trends in child injury death rates. While many of the rates have declined in the past 10 years, poisoning and suffocation have not declined. After the release of the *World Report for Child Injury Prevention* by the World Health Organization (WHO) in 2008, DUIP decided to refocus attention on the problem of child injury in the US. DUIP's partners recommended the NAP to coalesce the disparate partner groups with interests that cut across child injury topics. DUIP and its partner organizations identified six domains for the plan and created workgroups for each domain, including: Research, Surveillance, Communication, Education, Healthcare and Health Systems, and Policy. The NAP includes enough specificity to be actionable, but is sufficiently broad to allow the division to be opportunistic. The creation process took longer than they hoped; however, it was critical to be consistent across topic areas, to create specific actions, and to present a unified voice.

For the document to have substantive meaning, DUIP must support its implementation. DUIP supports nine implementation grants that focus on strengthening collaboration among key stakeholders; providing tools to the field to improve data and consistency in program execution; and showcasing the promise of evidence-based programs and building capacity in different settings. Five of the six domains in the NAP are represented in the nine funded projects. Policy is not addressed.

Dr. Baldwin has observed tremendous energy around the NAP, and those who have read the plan are impressed with its content and the direction that it sets. Their next tasks include catalyzing implementation success and maintaining momentum. When the process began, DUIP anticipated that its partners would garner focus and build a resource base to conduct the necessary work. He requested the BSC's input regarding how to ensure that implementation of the NAP will be a success, and for their recommendations regarding how and whether CDC should fund implementation work in the long-term.

### **Discussion Points**

**Ms. Castillo** observed that many partners contributed to the NAP's development. She asked whether partners are involved in championing the plan and whether a network is available to raise awareness and to garner support for its implementation.

**Dr. Baldwin** answered that DUIP convened a meeting in August 2011 with a core group of people to discuss implementation of the NAP. None of the partner organizations volunteered to be responsible for moving the plan forward, but one of the grant recipients, Nationwide Children's Hospital, proposed to organize partner organizations and to build a web portal to catalog materials and to provide a platform for those conversations.

**Dr. Fowler** asked about specific deliverables from each of the grant recipients.

**Gaya Myers** replied that the projects received their funding in September 2012, so conversations are on-going with each recipient regarding realistic deliverables within an 18-month timeframe and with a \$40,000 budget. The goals of the grantees address domains in the NAP. They vary and include developing workgroups, creating data systems, and developing templates. Each project is unique, and it is challenging to rally the field around the projects.

**Dr. Baldwin** provided further details about the grantees. The National Safety Council (NSC) is developing a web portal for employers to focus attention on child injury prevention. SafeKids has a long history of developing research reports and associated communication products. They will release a research report on the state of the science pertaining to infant suffocation and what can be done about it. The Society for the Advancement of Violence and Injury Research (SAVIR) will assemble the most valid and reliable instruments in the injury field, creating consistency across the field. The grantees' topics represent the burden of child injury through suffocation, motor vehicle injury, and functional tools. DUIP is using a Broad Agency Announcement (BAA) mechanism for this process. The BAA ensures fair and open competition and also codifies the multi-directional conversation regarding project ideas. Ms. Myers serves as the overall project officer for the grants, but subject matter experts (SMEs) from DUIP are participating as well.

**Dr. Greenspan** asked whether metrics or guiding principles have been developed to measure the success of the NAP.

**Dr. Baldwin** answered that the NAP is one component of DUIP's mission. The division wants the American people to understand the burden that child injury represents, as well as the opportunities to address the burden. Their vision for the field is to provide a roadmap for increasing focus, attention, resource support, and energy on the problem of child injury. Without a focus on child injury, the gains that the maternal and child health field has made in the first four years of life are lost. He expressed his hope for broader resource support for the field at large, the opportunity to conduct more programmatic work, and achievement of the goal to reduce the rates of child injury and death.

**Dr. Fowler** said that given the history of funding for prevention, it is not likely that people or groups will volunteer to fund the implementation of the NAP. DUIP's strategy could reflect a pragmatic approach. Instead of funding standalone programs that are "proof of concept" and then hoping to take the programs to scale for a national win, there may be ways to work within other areas that have better funding, interest, momentum, and constituents. For instance, issues of childhood obesity, education, and healthy, livable communities have symbiosis with injury.

**Dr. Baldwin** answered that with the help of Ms. Patterson, DUIP is building relationships with congressional members who have interest in the area of injury and who have reached out to NCIPC. While he is not against symbiotic connections with other issues, the process can be complicated. They have worked with colleagues in housing on child injury and residential fires. They have also worked with colleagues in chronic disease areas. Their challenge has been sustainability and maintaining momentum, because with current resource constraints, injury issues are eliminated if they are not high-priority in the partnerships. One of the goals of the NAP is to unite injury topics under a broad rubric of "child injury." He asked the BSC whether that approach merits further work. Individual child injury topics have strong advocates, but the rubric of "child injury" has not been as successful as DUIP had hoped.

**Dr. Fowler** asked whether "child injury" is the right rubric to discuss, as opposed to "child health" and "child wellness," including injury. The United States Department of Education (ED) and childhood educators must understand that the greatest threat to their success is not only gains in the first four years, but also injury, which threatens children's futures and their contributions to society. While educators are aware of some violence issues and bullying, their understanding of the scope and burden of injury is incomplete.

**Dr. Baldwin** indicated that a DUIP staff member has built relationships with the national Parent Teacher Association (PTA). DUIP representatives have presented at national PTA conferences on the *Protect the Ones You Love* initiative. The materials naturally resonate with those audiences.

**Dr. Nation** asked whether DUIP has a few messages that capture their vision of the goal of the NAP. If they can identify the greatest threat to a particular audience, they will have leverage with that group. He asked whether they utilize existing infrastructures at CDC with common interests, such as Coordinated School Health (CSH).

**Dr. Baldwin** replied that NCIPC is fortunate to have Dr. Lisa Barrios as the Acting Director of DARPI. Dr. Barrios was previously with the Division of Adolescent and School Health (DASH) at CDC and has worked on injury issues in schools for some time. DARPI presents the opportunity to build more bridges. For many injury topics, such as motor vehicle, the field understands the burden and what to do about it, but is not doing what is necessary to address the burden. DUIP's communications staff has encouraged bolder and more attention-grabbing

messages. For instance, the *Vital Signs* materials refer to “the number-one killer.” Regarding the relationship with PTA, he noted that *Protect the Ones You Love* is intended to build on the “bully pulpit” that mothers and primary caregivers have in the US to raise the visibility of injury issues.

**Dr. Borkowski** suggested focusing on the National Head Start Association (NHSA) and the National Association of Elementary School Principals (NAESP).

**Dr. Greenspan** suggested that rather than thinking of individual outcomes, they could think in terms of unifying risk factors. Many risk factors for unintentional injury are also risk factors for violence.

**Dr. Baldwin** agreed and noted that Dr. Degutis supports a focus on integration and risk factors. Within this age group, supervision and safe, stable, and nurturing relationships (SSNRs) are also important. Interventions such as Nurse-Family Partnership and others address issues pertaining to child maltreatment and violence prevention and can also assess the home environment for other hazards.

**Dr. Fowler** asked about how the three divisions integrate their work. In terms of messaging that focuses on risk, she pointed out that if people feel that they have control, they do not perceive risk. She wondered whether NCIPC should focus messages on risk, or if it would be more powerful to focus messaging on the ability to protect and control.

**Dr. Baldwin** commented on the “Living Life to its Full Potential” frame and agreed that the message is powerful. The *Protect the Ones You Love* health communications campaign has an emotional appeal with a positive frame. DUIP has built partnerships in topic-specific areas, and they are interested in doing more of that work.

**Dr. Spivak** pointed out that the kind of messaging depends on the audience. For instance, negative messaging does not work with adolescents, but it does work with adults. He expressed his hope that they would utilize the strong science regarding messaging.

**Ms. Patterson** said that her office has been contemplating how to communicate more effectively with policymakers. That audience does not respond well when the message begins with the burden. Over time, messages about burden lose impact. Therefore, messages focus on the landscape and what to do about it.

**Dr. Baldwin** pointed out that child injury is often the beginning of a broader conversation about unintentional injury. Most audiences are interested in vulnerable populations, such as children.

**Dr. Nation** noted that much of their messaging focuses on a specific “ask.” For instance, an audience of elementary school principals will want to know what they can do to address the problem effectively. School administrators face many burdens and will respond to a good argument about timely action that they can take.

**Dr. Baldwin** agreed, indicating that DUIP has worked with SafeKids to leverage their local coalition groups regarding the NAP. AAP has also been a strong partner in the NAP, as pediatricians play a strong role in providing anticipatory guidance on injury measures.

**Dr. Grossman** observed that the *Protect the Ones You Love* message could also be applied to an immunization campaign, and he wondered about the extent to which DUIP has collaborated internally at CDC with immunization programs. There is renewed interest in vaccine hesitancy and the need to promote vaccines in a manner that has not been necessary in the past. CDC could create a “child protection package” and integrate injury prevention into a larger domain of child protection, with cross-messaging and packaging information together. **Dr. Baldwin** replied that they have not yet embarked on this type of work, and he thought it was a good suggestion.

**Dr. Fowler** observed that *Protect the Ones You Love* is individually-focused as opposed to population-focused. Most citizens are aware that immunization is not only about protecting an individual child, but is also part of a larger social system. She wondered how to bring a broader vision to *Protect the Ones You Love*.

**Dr. Baldwin** responded that *Protect the Ones You Love* concentrates on parents and caregivers, and its messages have not emphasized broader infrastructure requirements. However, other NAP efforts are underway. For instance, NIOSH is working with children in agricultural settings. At the global level, conversations focus on children growing up in adverse circumstances. USAID is a promising global partner.

**Dr. Li** observed that Healthy People 2020 addresses CDC’s *Guide to Community Preventive Services* (referred to as the *Community Guide*) and asked how the NAP relates to Healthy People 2020.

**Dr. Baldwin** answered that Healthy People 2020 includes metrics for reductions in burdens that crosswalk to the NAP’s goals. The NAP is the “game plan” for reducing those burdens. For instance, the NAP addresses the need to build topic-specific research agendas by child injury area to set the course for the field’s research investments. The NAP is not substantively tied to Healthy People 2020, but the NAP is referenced broadly in Funding Opportunity Announcements (FOAs). The Consumer Product Safety Commission (CPSC) has expressed interest in creating an NAP for older adults.

**Dr. Fowler** asked if DUIP can fund projects that look specifically at integration activities. **Dr. Baldwin** answered that the BAA mechanism is intended to do that. The project at Nationwide Children’s Hospital to unite the partner organizations will be helpful. Dr. Gary Smith, the Principal Investigator (PI), is savvy regarding outward messaging.

### **Prescription Drug Overdose Prevention Strategies**

**Grant Baldwin, PhD, MPH**  
**Director, Division of Unintentional Injury Prevention**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Baldwin** indicated that prescription drug overdose prevention is an unofficial winnable battle for CDC. Since 1999, there has been a four-fold increase in prescription drug overdose fatalities in the US, largely due to opioid analgesics. As CDC understands more about the burden and the risk factors, they recognize the important role that the agency has in attending to the issue. NCIPC formulated a strategic direction that honors and is appropriate for CDC’s niche. The strategy includes three categories of activities: strengthening surveillance, with an emphasis on PDMPs; improving clinical practice, with an emphasis on guidelines and

integration of data into clinical workflow decision-making; and strengthening policies, laws, and regulations.

CDC is pursuing six areas within the three categories, which are more particularly described as follows:

- ❑ PDMPs are authorized in 42 states and are funded in slightly fewer states. States have operationalized these programs to catalog the movement of controlled substances within their states with varying levels of resource support.
- ❑ PRR programs, or Medicaid lock-in programs, exist within the health infrastructure. Insurers or the Medicaid system are able to identify problems and restrict patient pools to one doctor or pharmacy.
- ❑ CDC has catalogued the laws, regulations, and policies regarding prescription drugs in all 50 states. The catalogue includes laws, regulations, and policies addressing Good Samaritans, doctor-shopping, pill mills, tamper-resistant forms, and physical evaluations prior to dispensation of controlled substances.
- ❑ Methadone is 1/18 the cost of the next-cheapest opioid and is increasingly being used for pain and not just for withdrawal and substance abuse treatment.
- ❑ CDC is focusing on insurers and pharmacy benefit managers, creating systems so that insurers institutionalize clinical guidelines to ensure responsible prescribing.
- ❑ With a range of partners, CDC is working on the development of evidence-based guidelines and on translating those guidelines into Information Technology (IT) systems for ready access by clinicians.

NCIPC's work on prescription drug overdose prevention largely focuses on chronic, non-cancer pain. They have a bifurcated goal, which is to safeguard access for patients who have legitimate need for these medications while simultaneously addressing use, misuse, and overdose.

Dr. Baldwin requested the BSC's feedback regarding how to develop projects to build the science base to determine the efficacy of interventions and how to support the adoption of the strategies.

### **Discussion Points**

**Dr. Grossman** thinks the topic of prescription drug overdose is ideal for the *Community Guide*. The United States Preventive Services Task Force (USPSTF) has engaged in some work on this issue. One of their challenges will be to assemble sufficient evidence for the USPSTF to address effectiveness. DUIP can help generate knowledge regarding effectiveness and policy.

**Dr. Baldwin** said that the funding in the domains will lead to answers. They convened an expert panel on best practices for PRR programs, including the critical elements of success in different states. The programs diverge in their administration and in the decision-making process. The Alliance of States With PDMPs, a non-governmental organization (NGO), released a white paper on best practices for PDMPs. Much of this work is consensus-driven and does not meet the level of evidence required for the *Community Guide*. The burden is too

great to do nothing, but it is essential for DUIP to build evidence so that benchmarks such as the *Community Guide* can codify the recommended actions.

**Dr. Grossman** asked whether DUIP is conducting state-level analyses in the states that have PDMPs, and whether they will be able to assess the effects of early intervention versus late effects of the programs.

**Dr. Baldwin** answered that DUIP has adopted a case study approach. They are discussing how to work with the state health department in Washington to assess the differences in clinical and health outcomes before the implementation of the PDMP model there. They have also met with representatives from the PDMP in Maryland. There are significant variations in funding levels for the programs. DUIP has identified potential public health opportunities that exist within PDMPs, as they can be used for population-level surveillance work. With the US Food and Drug Administration (FDA), DUIP is co-funding a PDMP surveillance tool to link and de-identify data across five states to improve their understanding of the risk factors related to prescription drug use. He hopes to create a system to support this work in the long-term.

**Dr. Grossman** suggested investigating the program at the medical practice level as well as the state level. The HMO Research Network could have useful data. The network includes 14 million lives, and the Kaiser regions and other large HMOs are involved in it. A number of HMOs have introduced aggressive policies at the practice level. It might be possible to compare outcomes within those groups, which have excellent data systems.

**Dr. Baldwin** acknowledged that the network could be an avenue for broader engagement. They have worked with select managed care organizations (MCOs) to discuss how they operationalize clinical guidelines in their IT systems and how they hold their providers and clinicians accountable for practice. DUIP is also working to integrate PDMP data into HIEs.

**Dr. Grossman** volunteered to connect DUIP to the HMO Research Network. He noted that the network is connected to the FDA for prescription monitoring.

**Dr. Baldwin** commented that FDA is moving forward with a focus on provider education. Provider education is “one leg of the stool,” and he asked for feedback regarding provider education as a solution.

**Dr. Grossman** said that the science on provider education indicates that it “is one of the weaker legs of the stool.” Changes in medical practice come about through academic detailing and interpersonal, small-group engagement. The evidence shows that media such as streaming video do not change physician behavior. Accountability, transparency regarding behavior, measurement of outcomes, and feedback will change physician behavior. These elements emerge at a group level or when the physicians report through a multi-stakeholder alliance. These alliances among purchasers, health plans, and providers are reporting data in Massachusetts and Minnesota. They have created metrics that provide data on clinical performance. This powerful tool may motivate physicians to change practice.

**Dr. Baldwin** agreed with the importance of provider education relative to other strategies. DUIP and NCIPC are actively involved in multi-stakeholder engagement. They have partnered with the National Governors Association (NGA) and ASTHO to bring together state teams with broad representation, including law enforcement, state medical boards, state health departments, governor's offices, and other sectors. NCIPC is funding five states to utilize these teams to develop state-specific action plans related to prescription drug issues. This engagement includes representatives at senior levels, which underscores the importance of the issue in the states.

**Dr. Fowler** asked about research or evidence regarding the level to which patient satisfaction scores drive provider behavior on this issue. When a provider is deciding whether to prescribe opioids, one set of guidelines may encourage him to be responsible while the satisfaction scores may encourage a different action.

**Dr. Grossman** shared an anecdotal observation that his institution's policy has led to some disgruntlement. He agreed that there are incentives to improve patient satisfaction scores, but he did not feel that the issue would impact much of the provider population.

**Dr. Baldwin** said that DUIP is seeking balance on this issue and is engaging with pain care societies and pharmaceutical companies. Pain is the fifth vital sign, and pain is a concern among children. DUIP is funding projects in Spokane, Washington and in North Carolina regarding Consistent Care Programs. These programs focus on "doctor-shoppers" and patients who visit emergency departments or urgent care facilities in multiple settings in a region. Historically, the health IT systems do not communicate. The Consistent Care Programs allow emergency departments to have access to prescription information. DUIP looks forward to evaluating whether these programs are effective.

**Dr. Fowler** recently heard a presentation by the National Highway Traffic Safety Administration (NHTSA) on the prevalence of opioid-related motor vehicle crashes, and she wondered about increasing surveillance of these incidents.

**Dr. Baldwin** answered that DUIP met with NHTSA the previous day. "Drugged driving" is a prominent issue for the NHTSA Administrator and for the CDC Director. The issue is complicated because, unlike alcohol-impaired driving in which risk can be easily catalogued, it is more challenging to assess impairment levels for drugs.

**Dr. Fowler** recalled financial incentive programs for state police. The programs were instituted to increase the level of reporting of alcohol-related fatal crashes. She wondered about similar incentive programs to increase the level of drug reporting in fatal crashes. She recognized that evaluating drug levels in the living is challenging. Financial incentives encouraged law enforcement to work with the death investigators to reach a level of 100% screening for alcohol in fatal crashes.

**Dr. Baldwin** said that DUIP has been working with NAME and coroners' associations to reach agreement on practice and definitions regarding what constitutes an opioid-related death and how it should be catalogued.

## **Division of Violence Prevention Update**

**Howard Spivak, MD**  
**Director, Division of Violence Prevention**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Spivak** described the new program *Essentials for Childhood*. It will be rolled out as a public initiative and will include funding for four to six state health departments to implement aspects of the program. A technical assistance package is included to work with the funded states and with other state health departments that are interested in creating plans and identifying or redirecting resources for the program. Many parenting programs are funded, but they do not work. States may desire to redirect that funding into parenting programs that do work. This program elevates the child maltreatment agenda within NCIPC and makes it more visible outside of the agency. DVP is considering collaborations with other agencies. The Administration for Children and Families (ACF) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) have initiatives that focus on children and safety. These initiatives target high-risk children, as opposed to *Essentials for Childhood*, which is oriented toward primary prevention.

DVP is putting its technical assistance work in youth violence prevention out to bid. In the past two cycles, the major agenda has focused on engaging with cities on the topic of youth violence and helping them develop plans and strategies for addressing it. This cycle takes a slightly different approach. The grantee will be required to develop Memoranda of Agreement (MOA) with three to five cities. In these agreements, the cities will each identify \$2 million of resources for the issue. The grantee will work with the cities to help them identify resources that may not be effectively spent and / or can be redirected. The grantee will also engage with city government departments which are not typically engaged in violence prevention, such as recreation, housing, and community development. The grant includes expectations for concrete outcomes in violence indicators. It is not clear whether these outcomes will be achievable, but it is important to move forward to “put our money where our mouth is.”

Some areas in violence prevention, such as sexual violence (SV) and intimate partner violence (IPV), have limited evidence bases, but receive high levels of funding. DVP plans to integrate more program improvement and outcome evaluation into those areas. Budget language does not restrict this work in IPV, but there are fewer resources in that area than in SV. Language in the Violence Against Women Act (VAWA) restricts use of SV funding to certain activities. The funds cannot be used for research, including evaluation, even though evaluation can result in data regarding promising and effective programs. DVP is trying to integrate evaluation into the SV programs, which represent the largest investment of NCIPC. They hope to maintain important relationships in a positive way while moving the field forward.

DVP is investing resources in community change initiatives and their effects on violence prevention and rates of violence. They are collaborating with CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) on place-based interventions, parks, and other open-space initiatives in communities. They will meet with Local Initiatives Support Corporation (LISC), the technical assistance agency that works with community development corporations around the country. They collect data, but not health data. DVP hopes to work with LISC to gather information on health outcomes from these true population-based interventions.

## **Discussion Points**

**Dr. Nation** asked whether the SV funding allows for surveillance.

**Dr. Spivak** answered that the VAWA legislation stipulates that the funding is used for a specific scope of activities. The activities include rape crisis centers, which are intervention efforts, and some prevention activities. DVP has worked with rape crisis centers and other interventionists to help them understand prevention and the importance of stopping the flow of violence, because there will never be enough resources for response services. The evidence base is not strong, so it is not clear how to guide the programs. The programs engage in a range of activities, some of which are ripe for evaluation. This evaluation is important to advance work broadly around the country. A total of 57 programs operate in the US. The funding formula is population-based, so funding levels to the states vary.

**Dr. Nation** recalled DVP's intention to expand to parks and other places. He wondered whether the technical assistance focuses on programs, policies, or practices.

**Dr. Spivak** responded that technical assistance focuses on programs, policies, and practices. Youth violence prevention requires comprehensive strategies that include public policy, regulation regarding issues such as alcohol accessibility, the physical structure of communities, the value systems in communities, the skill levels of individual children, and other factors. There is no single approach to the problem of youth violence. There is encouraging information about comprehensive approaches, but the studies have not been formal, so comparisons are not available. It is clear, however, that individual programs do not make enough of a difference to impact serious outcomes.

**Dr. Nation** asked whether DVP plans to overlap with the Promise Neighborhoods efforts, which include people who are concerned with health and outcomes for children.

**Dr. Spivak** said that the relationship with LISC will help in this area. The National Forum for Youth Violence Prevention is a larger federal initiative that involves the ED, the US Department of Justice (DOJ), the US Department of Housing and Urban Development (HUD), and other agencies to align efforts. When programs are in the same city, they are required to be connected in various ways. This initiative is likely to lead to a substantial relationship with OJJDP, with formal agreements regarding resources, strategies, and alignment.

**Dr. Linares** indicated that she was part of the SV portfolio review. The review committee commented on the overlap of what the field knows about the different kinds of abuse. The evidence base on SV is limited, but the risk factors are similar to other forms of abuse. Evidence-based programs could be adjusted for SV, based on shared risk factors.

**Dr. Spivak** agreed and indicated that one of his goals is to improve the connections among the different forms of violence. The Rape Prevention and Education (RPE) programs in the states are assessing successful models in other areas of violence. If the setting is accommodating, RPEs will consider similar strategies. Communities look at violence in comprehensive ways, and therefore programs should enter communities in a more comprehensive way to engage them more deeply. There are overlapping perceptions, as well as overlapping risk factors.

**Dr. Linares** said that the SV review committee discussed clarifying specific aspects of certain presentations of violence versus aspects that are common or general to violence.

**Dr. Spivak** agreed that there are common points among all forms of violence. For instance, exposure to violence in early childhood is a risk factor that crosses all of the boundaries. That risk factor makes the *Essentials for Childhood* project all the more important.

**Dr. Linares** added the importance of the language of these risk factors. For example, she and her colleagues are considering “toxic stress;” what it does to the lives of children; and how it affects behavior, learning, and function.

**Dr. Spivak** said that DVP is reestablishing the Adverse Childhood Experience Study (ACES), which was administered by NCCDPHP. DVP plans to look at new ways to use that approach at an international, as well as a domestic, level.

### **Division of Analysis, Research, and Practice Integration Update**

**Lisa C. Barrios, DrPH, ScM**  
**Acting Director, Division of Analysis, Research and Practice Integration**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Barrios** reported that DARPI is about six weeks old. Its mission and purpose is to bridge science and practice in both directions, translating science to practice and sharing information from practice with analytical and evaluation work. Their initial work involves developing processes to build those bridges. DARPI is cross-cutting and focuses on the systems and policy levels, as opposed to a specific injury area. The division considers multiple types of injuries, as well as precursors and protective factors across different types of injury issues. The division staff members have engaged in strategic planning to plot DARPI's mission and function and are now identifying its major projects in addition to administering the Core VIPPs and the Web-based Injury Statistics Query and Reporting System (WISQARS). She requested the BSC for feedback regarding which policy questions and cross-cutting issues the division should address.

### **Discussion Points**

**Dr. Fowler** suggested that Dr. Barrios and her colleagues engage with the BSC via the secure BSC website as their work moves forward.

**Dr. Barrios** concurred and noted that DARPI is developing the secure site. They have conducted surveys and interviews with division and center staff, and they have scheduled a call with the ICRCs to hear their input. They also work regularly with Safe States and SAVIR.

**Dr. Fowler** said that Dr. Feucht had shared abstracts of three grants funded by NIJ that focus on prescription drug monitoring. She passed the abstracts to Dr. Baldwin.

As there were no additional comments, **Dr. Fowler** dismissed the group for a break at 11:45 am. The meeting resumed at 11:51 am, with a confirmed quorum.

A 3D-style header graphic with a blue bar containing the text "Research to Practice Agenda".

## Research to Practice Agenda

**Arlene Greenspan, DrPH, MPH**

**Associate Director for Science, National Center for Injury Prevention and Control  
Centers for Disease Control and Prevention**

**Rita Noonan, PhD**

**Associate Director, Office of Program Development and Integration  
Acting Deputy Director, National Center for Injury Prevention and Control  
Centers for Disease Control and Prevention**

**Dr. Greenspan** explained that while NCIPC's Research Agenda is useful, elements of the agenda are problematic. In particular, the agenda does not have a strong tie to practice. NCIPC leaders have decided to develop a Research ↔ Practice Agenda.

Unlike previous agendas, which are printed documents that are difficult to change, NCIPC envisions an online, living document that can be revisited and updated on a regular basis. The Research ↔ Practice Agenda will incorporate practice, have a cross-cutting approach, and will incorporate impacts. Practice will inform research, and research will inform practice.

Leaders at NCIPC have begun preliminary discussions about the new agenda. The process will begin with the NCIPC focus areas, but the agenda will not be limited to the focus areas. The agenda will address research gaps and propose next steps in implementation, dissemination, and translation research to achieve public health impact.

**Dr. Noonan** drew the BSC's attention to the main questions that will drive the new agenda:

- What are the top research priorities, based upon burden and readiness to move into practice?
- What promising practices need to be tested in a real-world setting, modified if necessary, and taken to scale?
- What are the practice issues that need evidence (either more evidence or better evidence) in order to advance the practice field?

DVP began work several years ago on an interactive systems framework to assist in thinking through a framework, action steps, and research questions that will help close the gap between research and practice. The direction of the new agenda is not new to NCIPC, but they have not deliberately addressed how to attend to and develop the interface of research and practice in the short-term. This agenda differs from what NCIPC has done in the past. It recognizes the center's efforts to increase the flow between research and practice and to close gaps.

## **Discussion Points**

**Ms. Castillo** said that NIOSH has been aggressively involved in research-to-practice issues. They have integrated guidance on research-to-practice into all of their projects, and any new activity must include a research-to-practice plan. She offered to share NIOSH's guidelines with NCIPC. Incorporating research-to-practice at the project level ensures that it is integrated across all of NIOSH's activities and advances their work. Projects range considerably, but the guidelines encourage upfront engagement with stakeholders to ensure that they agree with the research question, they will be receptive to the research results, and they will move forward based on the results. National academies review various elements of NIOSH's programs and make recommendations. One of the recommendations pertaining to the injury section expresses support for the concept of research-to-practice but suggests formal evaluation to assure that the efforts are worthwhile and that the time was well-spent.

**Dr. Fowler** suggested that NCIPC consider requiring developmental/formative and process evaluation rather than only outcome evaluation. It is important to learn whether programs are working and why they are working or not. They will not be able to evaluate research-to-practice and back without better formative and process evaluation data.

**Dr. Feucht** encouraged NCIPC to review the William T. Grant Foundation's work in research-to-practice. The foundation is investing in understanding research uptake at a fundamental level, including obstacles and avenues to research utilization. DOJ has been inclined to ask similar questions of their practitioner base.

**Dr. Grossman** noted that guidelines are an important avenue to changing practice. The absence of evidence to generate a positive recommendation can be a barrier to progress. He suggested that NCIPC consult the *Community Guide* and USPSTF for areas in which the evidence was insufficient to make recommendations. That information will help the center understand and itemize gaps and find opportunities to close the gaps with specific research questions. The research questions could convert an "insufficient evidence" recommendation to a positive or a negative recommendation.

**Dr. Barrios** added that the *Community Guide* is considering how to move interventions with sufficient evidence into practice. She asked the BSC how specific they should be regarding interventions that are ripe for practice.

**Dr. Fowler** said that clarity regarding the interventions that do work will be helpful, as resource reallocation is important when new resources are not available.

**Dr. Greenspan** pointed out that some of the *Community Guide* recommendations may still need to be translated so that practitioners can use them more easily.

**Dr. Fowler** suggested that NCIPC think broadly about the definition of "practitioner." Does injury prevention-related research need to be implemented and practiced by "injury prevention people," or are there ways for other people to translate research into practice?

**Dr. Noonan** asked the BSC where this agenda could take the center, how to gain the maximum benefit from it, and what they should do with the agenda beyond promoting and disseminating it in the usual manner.

**Dr. Grossman** suggested widely disseminating the agenda among other agencies that might have funds to devote to these areas. NCIPC can lead the agenda, but it can serve as a broader, HHS funding agenda so that other groups will find it useful and integrate elements of it into their own agendas. It will get more leverage with that approach, given the current funding climate.

**Dr. Greenspan** asked who NCIPC should engage as stakeholders and partners in the development of the agenda.

**Dr. Fowler** encouraged NCIPC to think beyond HHS, offering the example of NIJ's funding for prescription drug issues. Other funding stakeholders should be part of the discussion, especially given that the agenda will address cross-cutting issues.

**Dr. Baldwin** agreed with the concept of gathering input from some partners, but noted that if they broaden the pool of people involved in developing the agenda, they will extend the time horizon for completing the agenda.

**Dr. Fowler** suggested that NCIPC could begin to work with the established federal liaisons on the BSC. NCIPC can make it clear that the document is living and adaptable to input. She asked whether their consideration of evidence focuses on types of injury or on types of strategy, which could be cross-cutting.

**Dr. Noonan** said that NCIPC staff and partners would vet this question. The agenda should take into account where NCIPC make a difference quickly.

**Dr. Degutis** clarified that the intent of the agenda is to achieve rapid results. The development process should not take years. Because the agenda will be a living document, they will have opportunities to tweak and amend it as needed. The new agenda will represent a reframing of the center's agenda so that their work will look different from how it has looked for the past 20 years. In this era, they look for quick "wins." She agreed with the need to engage other partners, but thought that NCIPC should capture its own ideas first. They will also build the agenda into their FOAs and other center activities. Recent FOAs for the ICRCs included a requirement for practice partners on their advisory groups. The Core VIPP program is linking to the ICRCs in various ways as well.

**Dr. Fowler** indicated that she participated on the Core VIPP portfolio review panel. The panel observed that one of the limitations of the program was the lack of evaluation data coming out of the Core VIPP programs and the states. ICRCs or DARPI could help build evaluation capacity in those programs. The review panel also stated that the injury field needs at least one dramatic "win" on a national scale. They were concerned that the fire and smoke alarm program, which demonstrated some impact, was never taken to scale. The panel also made the controversial recommendation that states should not be eligible for programmatic funding until they have demonstrated capacity at the fundamental level. For instance, in order to be effective, states should be able to conduct surveillance and use data strategically; perform strategic convening; and conduct policy work. If research-to-practice translation is important, then NCIPC's programs should emphasize building infrastructure before investing program money.

**Dr. Barrios** replied that the center's evaluation team is growing and will be able to provide more support. They have worked with the state programs to develop specific indicators and to strengthen their evaluation programs.

**Dr. Nation** asked whether NCIPC has identified specific strategies for encouraging the research-to-practice process. Building strategies for improving research-to-practice into the funding process will be helpful. If they focus on data-based decision modeling, then the Request for Applications (RFA) requirements can ensure that applicants have that capacity.

**Dr. Noonan** answered that they had not explicitly addressed those strategies, but they do discuss them in general. For instance, the center considers how to encourage the use of evidence and what the next steps are when good or sufficient evidence is not available. DVP has a project that examines what constitutes evidence. NCIPC also considers how to encourage innovation and exploration around community-based initiatives and community mobilization efforts that create population-level change, but that might not be included in a compendium of effective interventions.

**Dr. Greenspan** added that they are revisiting the next ICRC FOA to incorporate a research-to-practice model. She asked for feedback and ideas from the BSC regarding how they may have instituted these ideas.

**Dr. Linares** encouraged NCIPC to explore the emerging dissemination science research. She works in child welfare and trains child welfare workers. She and her colleagues have considered what it takes for workers to embrace a new program. Unfortunately, effectiveness of the program is never at the top of that list. They must be mindful of the conditions and of the paradigm shift that child welfare workers will have to undergo in order to embrace what is known.

**Dr. Noonan** agreed that good evidence is available regarding who and what influences adoption. Network analyses on these influencers would be useful. The importance of influential people in a dissemination strategy has been demonstrated in other fields.

**Dr. Linares** added the question of how to assess the readiness of a system for implementation.

**Dr. Noonan** agreed that management models address the climate for implementation and not just the individual perception of a person. The new agenda will apply these concepts to the field of injury.

**Dr. Li** noted that the agenda and dissemination strategies involved all of the topics that they had discussed thus far, from finding community partners and stakeholders to various dissemination approaches. He conducts dissemination research and has observed a number of factors that affect it. There are many public health promotion models, and he has observed the need for different strategies for different audiences. CDC and the Administration on Aging (AoA) have recommended his falls prevention program, and he suggested that CDC could offer input to AoA and CMS on providing technical support, including train-the-trainer support and materials, in the implementation process. Medicare encourages practitioners to perform fall risk assessments and is building incentives for these assessments. These examples illustrate a flow from research to community practice. He has learned a great deal from his practice and has generated questions for new research. The process, and therefore the agenda, should be on-going.

**Dr. Noonan** said that because Dr. Li's falls prevention program is in CDC's *Compendium of Effective Fall Prevention Interventions*, strategies for promoting the uptake and effective use of that program are different from other programs in the field.

**Dr. Fowler** asked whether NCIPC's conversations also address research-to-policy or research-to-regulation.

**Dr. Li** noted that evidence-based or community-research-based programs make an impact when they are incorporated into policies. CMS, for instance, adopts programs that make significant impacts at a societal level.

**Dr. Degutis** clarified that the center thinks of policy as a piece of practice.

**Ms. Patterson** pointed out that the afternoon's discussion would focus on a policy framework for NCIPC. She envisioned the policy framework building on the research-to-practice agenda. She offered the example of research informing practice, which in turn informs policy through such mechanisms as reimbursement.

**Dr. Fowler** said that the ICRC at Johns Hopkins created a *Research to Policy Guide*.

With that, **Dr. Fowler** dismissed the group for lunch at 12:32 pm. The group reconvened at 1:46 pm, at which time **Dr. Fowler** conducted a roll call and established a quorum.

### Demonstration of the New BSC Secured Website

**Darryl Owens**

**Web Designer, Statistics, Programming, and Economics Branch  
National Center for Injury Prevention and Control  
Centers for Disease Control and Prevention**

**Mr. Darryl Owens** demonstrated SharePoint and the BSC's secured website, reviewing the following topics: how to register for the site, Conditions of Use of the site, validating the user profile and creating a password, accessing the site, what SharePoint is, and definitions of terms. He explained that BSC members should register for the site via a link in an email. The Conditions of Use remind users that although they utilize a personal computer to access the site, they are connected to a federal government network. As such, there is no reasonable expectation of privacy. The government does not monitor information on users' personal computers. The government network only includes the information transferred to the system.

Mr. Owens explained the process for creating a username and password. If members leave the BSC, their access to the secured website will be disabled. If members then return to CDC in another capacity, their profiles will have remained in the system and will only need to be reactivated, not recreated. He then described security measures offered through Microsoft and options for logging on to the system using a private computer or a shared computer. Members should close their browsers after accessing the site.

SharePoint is a collaborative tool that enables teams to work together on different tasks. The program enhances document management, provides reporting, automates business processes, and integrates with existing systems. SharePoint includes "libraries" of files that users can manage or manipulate. It also includes "lists" of items such as contacts and calendars. Users of SharePoint should know how to use Microsoft Windows, Microsoft Office, and how to browse the web.

Mr. Owens then demonstrated the utility of the site to create and edit documents, tasks, and calendar events. The site can track workflow on a document as it is edited and through the review and approval process.

### **Discussion Points**

**Dr. Fowler** asked whether all of the functions of the site were open to all members, including setting meetings, or whether there were levels of access.

**Mr. Owens** answered that there are different levels of access to SharePoint. BSC members will probably have “contributor rights.” They can manage and manipulate documents, but they will not be able to do certain other things on the site. He assured the BSC that all of the information on the site is backed up.

**Dr. Fowler** clarified that only BSC members who were attending the meeting in person received the email invitations thus far. The invitations will eventually be sent to all BSC members and federal liaisons.

As there were no additional questions regarding the secured website, Dr. Fowler dismissed the group for a break at 2:30 pm. They resumed at 2:40 pm, with a quorum confirmed.



### **BSC Discussion and Dissemination**

**Dr. Nation** observed that the morning’s presentations shared a common theme of challenges involving evidence and dissemination. Some projects have sufficient evidence to support them, but are not disseminated. Other projects are disseminated, but do not have strong evidence supporting them. The question of generating and disseminating evidence is significant. The current model begins with surveillance, which is a grassroots-driven effort to gather information from communities and worksites. The research and evaluation function is project-based and resource-intensive, and it is questionable whether this function is sustainable in the current funding climate. The final step, dissemination, is grassroots in nature.

In sum, the dynamic is somewhat disjointed as the field considers potential evidence and best practices in communities and how to be more responsive to communities. Simultaneously, the field is considering how to disseminate evidence in a manner that is useful to practice. Technology offers opportunities to create real-time portals and mechanisms. In his experience, people resist evidence-based lists, in part because the lists are static. By the time the lists are disseminated, they are often dated. NCIPC could invest in systems that are more time-sensitive and practice-driven, tying surveillance, evaluation, and dissemination together more tightly.

## **Discussion Points**

**Dr. Linares** suggested thinking about systems as a continuum, rather than a given point in time. Some communities could be at a “pre-evidence” stage and need basic science principles. Other communities could understand the evidence base and know that the evidence does not meet the needs of their population, and seek innovative ways to be effective. Thinking of communities and service delivery on a continuum will help in planning dissemination and implementation phases.

**Dr. Nation** recalled Dr. Spivak’s comments regarding SV, in which some programs are probably ready for systematic evaluation. The evaluation is important, but they do not have to wait for that evaluation to be conducted in order to have broad influence.

**Ms. Patterson** said that NCIPC released a one-year funding announcement focused on assessing states’ level of capacity to conduct evaluation or to partner with academic institutions for evaluation. Because the SV funding is formula-based, some states do not have enough funding; however, larger states are working on their evaluation capacity at the state and community levels. Examples of practice-based evidence will help guide the field forward. *Essentials for Childhood* and Striving To Reduce Youth Violence Everywhere (STRYVE) may be sources for syntheses of the evidence on youth violence prevention programs.

**Dr. Fowler** said that some people view “evidence-based” programs as a “package,” rather than as pieces of a package. When a community or organization considers adopting an evidence-based project, they may begin pruning it to fit their resources and needs. In doing so, they may prune the critical elements of the project that foster change. The field can do a better job of understanding the critical pieces of programs and the supporting pieces of programs so that critical pieces do not get cut. Significant costs are associated with outcome evaluation; however, when formative and process evaluation are incorporated into a project early in its timeline, costs are lower. This strategy is ideal to address resources challenges. The RPE programs initially included the best process model.

**Dr. Greenspan** asked Ms. Castillo how NIOSH deals with issues concerning resource challenges and choosing when to disseminate programs. She wondered how much practice and the needs of communities inform what NIOSH does, even if the evidence is not clear.

**Ms. Castillo** noted that NIOSH operates differently from NCIPC, as NIOSH views itself primarily as a research organization. At the same time, NIOSH recognizes that in order for their research to have value or impact, they must embrace practice. NIOSH works in a context-specific manner as it examines the state of the science around its research questions: Is the question at the basic science level, or does the field know about the burden and how to solve it, and the next steps are not occurring?

**Dr. Nation** acknowledged struggles in surveillance to get appropriate information from the state and community levels. With some adaptation, surveillance work can gather information about the types of innovations that people are implementing in the field and about the outcomes that they find. Information about those innovations and about the components of programs that are successful provides an evidence base. Innovation and adaptation occur in the field, so collecting that information and providing it to the people who provide direct services will be useful so that they can learn about the types of innovations and components that work. When

practitioners see the confluence of a program package that works with their populations and in their settings, then different types of dissemination are possible.

**Dr. Li** commented that many service providers with whom he works do not have knowledge about the evidence base. One of the field's challenges, then, is to educate them and to provide technical support. AoA requires that programs supported by federal dollars have an evidence base. The question then regards which program to choose and whether the providers have enough knowledge to implement the program. As a researcher, he does not want programs to be implemented "piecemeal." Maintaining fidelity is critical. At the same time, programs must accommodate real-world situations.

**Dr. Linares** added that most replications of programs fail.

**Dr. Greenspan** said that this problem could be rectified if they identify critical pieces of a package that have to be carried out in order for the program to be successful. Communities are not able to execute programs in ideal situations, and the more they understand about what needs to get done, as opposed to what would be nice to get done, the more impact will be derived.

**Dr. Li** said that CDC can play a role in this area by creating a solid evaluation plan to ensure that programs are implemented scientifically as well as practically.

**Dr. Borkowski** commented that complex intervention packages are usually the most effective. It is rare for a simple package to be effective. Most interventions take time and have component parts. It is also rare to be able to pinpoint which component parts of interventions are effective. Analysis is expensive and is rarely funded. As long as evaluation measures continue in approximately the same format, complex packages supported by good research can be applied in different settings. The applied settings always use less than the total package and generally administer the programs with less fidelity. Continued evaluation will yield information about the degree of effectiveness in different settings without tremendous expenditures of money.

**Dr. Barrios** said that other parts of CDC have good models for consideration. CDC staff in Reproductive Health and HIV have worked to identify critical elements of their effective programs for several years. They have packaged and disseminated those effective elements and have conducted some evaluation. Reproductive Health and DASH have collaborated on guidance on selecting, implementing, and adapting effective programs. These efforts help practitioners determine optimal solutions for their settings, time frames, and communities.

**Dr. Fowler** asked whether the "critical elements" of the programs are critical elements, or critical stages. For instance, elements of school education are reading and math. Stages of school education are first grade, second grade, et cetera. In terms of dissemination and success, an examination of critical stages may be more useful: one should not consider high school without completing first grade.

**Dr. Barrios** replied that the staged approach is applied when programs are selected and implemented. Programs should match a community's stage of development as well as its needs. CDC's Reproductive Health personnel have been working with the developers of interventions to identify the elements of the programs' content and methods that must be in place in order to achieve impact in another community. The theory behind the intervention design is an important part of this work. Another important part of the work is the evaluation results. For instance, a program may have to include role modeling in order to be successful.

Another program may have to include condom demonstrations, but the method could vary according to the setting.

**Dr. Nation** observed that the discussion was focusing not on the perfunctory selection of a project, but on a way of thinking that CDC is promoting among practitioners. He agreed that the best way to implement an intervention is to implement the full package with fidelity; however, if practitioners are not engaged in the conversation, communities may understand that they should implement programs from the evidence-based list, but they may not know how to implement the program and may not have the skills to implement it. They then disengage from the conversation, which is a loss to the field. Ideally, the thought process will engage practitioners, and they will come to the conclusion that a program should be implemented completely and with fidelity. Alternatively, the practitioners will engage in the thought process and generate innovative solutions and programs that can be tested systematically.

**Dr. Feucht** offered to share papers on this subject via email. The first paper is from the *Harvard Business Review* on evidence-based management. It builds a compelling vision of how managers think about their job of managing, how evidence infuses their thoughts, and how to ensure that evidence is part of the management process. The justice field does not often apply the idea of managing by using evidence. The other paper addresses evidence generating policy. The author states that when something is implemented, the group that implements it should commit to begin learning about how it is working through formative and process evaluation, and perhaps outcome evaluation. Every time a program changes, the opportunity arises to learn something and to make practitioners and policymakers feel equally responsible for evidence.

**Dr. Fowler** asked whether the funding mechanism could consider these issues. Cooperative agreement funding could encourage partnerships as part of the implementation process. Additionally, the funding mechanism could normalize the reporting of trouble or problems. In a recent grant process in her state, the grantees' final report answered the question, "What went wrong this time that you would hope would never go wrong again, and how will you fix it?" Further, the grantees specified skills and partnerships that they needed to develop to strengthen their work. The quality of that information was different from the information from reports that only focused on program success.

**Dr. Nation** observed the same situation in his work with schools. Grantees talk about how fantastic their violence prevention program is, but in private, they disclose their difficulties. Those difficulties are instructive to others in the field. A strong environment will include lessons learned, as well as opportunities for collecting information along the way. The system will become more responsive and more timely.

**Dr. Spivak** characterized the issue as an internal struggle to understand and define the continuum of evidence. The continuum is difficult to communicate externally. He hoped that they would pursue a hybrid model that would incorporate working with communities and learning how to implement the evidence-based programs with some flexibility while allowing for the injection of new ideas. This approach would both apply and advance the field.

**Dr. Fowler** added that the BSC also discussed how to encourage people to engage in evaluation through the implementation process. That approach to evaluation is more affordable. She also summarized the conversation regarding normalizing reporting problems and how to create collaborative agreements for partnered implementation.

**Dr. Dahlberg** said that DVP staff members have worked to expand the notion of evidence. The evidence project has three components: the best available research evidence; fitting that evidence with contextual evidence in the population and community; and experiential evidence, which draws upon the people who work with the populations and live in the communities. DVP has also worked on a systems framework to address general capacity and innovation-specific capacity to help communities adopt the evidence base. DVP will roll more of this work out in the coming months.

**Dr. Spivak** noted that the interpretation of “best available evidence” is not consistent. There is no clear standard to indicate when to endorse a program as evidence-based. Further, there is disagreement over appropriate methodologies. Some methodologies are so rigorous that they cannot be applied in communities where there is little control. The conversations about evidence are difficult, but constructive decisions and/or principles are important.

**Dr. Nation** recalled the morning's discussion about SV. There are good activities in SV. Practice will carry on through the long process of evaluating those activities, missing opportunities to benefit from the evaluation.

**Dr. Spivak** agreed and added that they must disseminate information about the programs even as they improve the evidence base around them.

**Dr. Li** observed that all implementers, such as communities and community centers, face budget constraints. He wondered about a means for encouraging innovation. Small grants could support people in the community and their partners to generate innovative ideas for sharing information effectively and practically. Such innovation could fill the gap between research and practice. CMS is seeking innovative projects that provide better healthcare and better-quality care at low cost.

**Dr. Baldwin** agreed with the notion of contextual and experiential aspects of evidence. Fidelity is a struggle as programs are scaled. He likened evidence-based programs to the chassis of a car. Many cars are built on the same core chassis, but the additions to the chassis make cars dramatically different. To extend the analogy to their work, fidelity to the chassis is important, and the evidence of the program success is the program's chassis. Contextual and experiential factors can tailor the other aspects of the program. Communities in different parts of the country are different; the same program cannot be operationalized in the same way in different places, but perhaps the same chassis can be applied.

**Dr. Barrios** has adopted an elements-based approach as well as an intervention-based approach. Many community programs are required to utilize evidence-based interventions, even if they do not fit with the community. She hopes to provide guidance to communities on selecting the right programs and implementing them with fidelity, or adhering to critical elements with an adaptation guidance. An elements-based approach focuses on the characteristics of effective programs and interventions, synthesizing the characteristics to the key points that are effective across interventions. Those results could serve as a tool to help communities create new programs or evaluate their on-going initiatives.

**Dr. Spivak** added that communities need to be at a certain point to accept an intervention. They have to “own the issue” and buy into possible strategies. As DVP works with communities, they are developing an experiential base of the key elements in the process. Many good programs have been unsuccessful not because the programs were bad, but because they were implemented inadequately or not received properly. The steps include

process, basic elements of the program “chassis,” and the flexibility to adapt the chassis to specific communities and environments.

**Dr. Linares** said that her work in child welfare has focused on identifying naturally-occurring environments. In child welfare, weekly family visitation is an example of that environment. The sibling unit is another example of a natural environment, as children learn to relate to others in that unit. Extracting key elements from evidence-based packages and placing them in naturally-occurring environments makes sense for social workers. Rather than teaching a new, curriculum-based intervention, this approach tweaks what the social workers already do, imbedding the successful principles into the ongoing and natural opportunities.

**Dr. Spivak** added that the approach also applies to larger, population-based interventions.

**Dr. Nation** commented that many of NCIPC’s resources are devoted to grants and projects that are resource-intensive. He encouraged NCIPC to think of ways to tap into the experience represented in those grants and projects and to learn from it so they can tap into some innovations now.

**Dr. Li** said that the ACA has a patient-centered focus. He suggested that their research adopt a community-centered approach. The FOAs currently have strict guidelines for fidelity and dissemination, which could loosen.

**Dr. Fowler** asked how the BSC and NCIPC could move forward on these ideas so that the conversation could continue and be useful.

**Dr. Greenspan** answered that the SharePoint website is an informal way to maintain the conversation. As the Science-to-Practice Agenda Workgroup evolves and develops, they can incorporate the BSC’s feedback more formally and share elements for the BSC’s input on an ongoing basis.

**Dr. Spivak** commented that some of their discussion represented a cultural shift not only at NCIPC, but also at CDC. Outside support and validation of their direction is helpful.

**Dr. Baldwin** said that the issues are central to DUIP’s work in older adult falls prevention, especially as they release the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) toolkit. He suggested using STEADI as a test case, as the long-term success of STEADI relies on its widespread adoption, the fidelity of its utilization, its inclusion in reimbursement structures, and other areas. **Dr. Greenspan** said that Dr. Noonan had suggested using falls as a model starting point.

**Dr. Fowler** added the possibility of bringing practitioners and / or community representatives back into NCIPC’s advisory structure, noting that this issue was on the agenda for the next day of the BSC meeting.

**Dr. Barrios** said that they struggle because of a lack of methods that can determine the usefulness and effectiveness of the elements-based approach. They should consider how to evaluate in a cost-effective way. A community-centered approach means that every community will have a different intervention, so they must determine how to evaluate the work to show effectiveness.

**Dr. Fowler** suggested that developmental evaluation was created to address this question. Sometimes formal evaluation is not feasible, and it also may not be appropriate in every context. The need of the field will drive the development of evaluation methodologies.

**Dr. Spivak** said that methodologies are available, but they are not necessarily being used. Qualitative research works, but the field is cautious in accepting it.

**Dr. Fowler** said that technical assistance at each step may be needed in order to achieve outcomes.

**Dr. Li** observed a paradigm shift in research methodology. More grant applicants are proposing programs that are community-based and that involve multiple levels, from the individual to communities, neighborhoods, cities, states, and regions. This approach allows for generalizable findings and policy implications. The studies can be formative and assess contextual effect at multiple levels.

### Engaging Public Health Practitioners in the Policy Process

**Sara Patterson, Associate Director of Policy  
National Center for Injury Prevention and Control  
Centers for Disease Control and Prevention**

**Mighty Fine  
American Public Health Association**

**Ms. Patterson** described a collaborative project between the American Public Health Association (APHA) and NCIPC. The policy office at NCIPC works on Congressional relations, legislative analysis, and partnerships. They also track and analyze state policy. They have recognized a need in the field and internally at CDC to understand how to conduct policy work and capacity-building. They need a framework to guide their thought process regarding policy. They began the project with internal and external key informant interviews and a literature review. She expressed hope that the BSC would share their ideas regarding how to take the broad framework to the next level of prioritization that can yield recommendations to guide the field.

**Mr. Mighty Fine** added that in addition to interviews and a domestic and international literature review, the process included focus groups and surveys. It became clear that the policy process is somewhat nebulous. This framework represents an attempt to make the process less nebulous and more streamlined.

The framework describes the epidemiology of injury. It also addresses policy challenges, defining “policy” with the new CDC definition as well as with definitions from the Institute of Medicine (IOM). One section of the framework addresses policy lessons. That section uses tobacco as a model, but that choice is up for debate, as there are strong lessons to be learned from injury policy as well. The next section of the document addresses the policy cycle and uses CDC’s model for the policy process. APHA called for case studies of successful policy at the state level and selected one intentional case study and one unintentional case study. The document concludes with a list of resources and will also include information on next steps.

**Ms. Patterson** said that when the process began, they anticipated creating an aggressive and forward-thinking framework on how to do policy work. The climate has changed since the process began, and as a result of agency feedback, the framework is a “toned down” version. Their next steps are to prioritize and to make recommendations, especially given opportunities in the ACA, opportunities concerning shared risk factors, and the research-to-practice agenda. The field can also build on to this framework and perhaps make aggressive and progressive recommendations. The BSC was asked to address three discussion questions regarding the policy framework:

- What are the gaps in the framework?
- What do we need to do to unify the policy efforts of the injury and violence prevention community, especially when partners have diverse interests?
- What would be three overarching priorities that could be used to advance the field of injury and violence prevention policy?

### **Discussion Points**

**Dr. Fowler** asked about the risks and benefits of this document serving as an NCIPC policy advisory document, versus the document coming from APHA or another entity. Does NCIPC serve as a source of information and advisor, and therefore the document does not belong to them?

**Ms. Patterson** replied that one option is for NCIPC to lay out the framework and challenges, providing the analytic pieces of the document, and then for APHA to create the recommendations and prioritization to build on the framework.

**Dr. Fowler** raised the issue of whom the document is meant to advise. The document states that it focuses on public health practitioners working in the field of injury and violence prevention. If their goal is to impact policy that addresses factors associated with injury and violence, will they achieve the most impact from a focus on the practitioner? They may achieve more impact if the document focuses on how to save lives through smart policy, thereby appealing to community organizations, schools, and other groups. Many practitioners in state health departments do not have sufficient power at the policy level.

**Ms. Patterson** said that NCIPC may view people as injury prevention practitioners who do not see themselves that way. Different terminology could help everyone see themselves in the message of injury prevention.

**Mr. Fine** said that they learned in their key informant discussions that personnel working in state health departments felt like “silent partners” in carrying policy forward.

**Dr. Fowler** said recent policy victories regarding healthy environments and safer environments may be better examples than injury-specific examples.

**Dr. Colpe** commented that she enjoyed reading the vignettes and approaches in the document.

**Dr. Degutis** noted that some of NCIPC's primary partners, such as Safe States and SAVIR, are also engaged in moving policy forward. She wondered about a way for those groups to endorse the document, even if it comes from APHA, as opposed to all three groups creating their own documents or guides through essentially parallel processes.

**Ms. Patterson** agreed. She has mentioned the framework to Safe States and has scheduled a call with SAVIR to discuss it. They have not shared the framework internally and wanted to utilize the opportunity presented by the BSC meeting to hear their feedback. They will gather input from BSC, NCIPC, and partners such as SAVIR, Safe States, and ASTHO regarding how to move the framework forward.

**Dr. Fowler** asked about a timeline for the document. **Ms. Patterson** answered that they are completing the initial development of the document. Their next step will be an on-going process of prioritization and engagement. **Mr. Fine** said he hoped that they could present it at the upcoming national Safe States / SAVIR meeting.

**Dr. Fowler** said that if they go to Safe States / SAVIR and ask for feedback on a version of the document, then the issue will forever belong to NCIPC and APHA. Conversely, if they present an open draft for feedback that the other groups could ultimately finish and own, then the feeling of ownership about the document will be different.

**Mr. Fine** replied that they have room in the timeline to ensure that the document is as complete as possible and to garner as much buy-in as possible. **Ms. Patterson** added that they would solicit thoughts from the APHA leadership regarding their level of engagement and ownership.

**Dr. Li** asked about the outcome or deliverable of the framework.

**Ms. Patterson** answered that the framework is the deliverable, but the prioritization will be the actionable piece of the process. The framework will serve as a guiding principle for how to engage in policy, and the prioritization process will hone in on the next steps. For example, formative and process evaluation is important for a range of topics, particularly on policies that work in the area of violence. In other areas, such as TBI and sports concussion, there is ample evidence for programs that work, and the field needs to get buy-in to move those programs forward. **Mr. Fine** added that the framework will provide a baseline understanding and approach to policy.

**Dr. Li** asked whether the focus groups included CDC grantees. Much of the work conducted through CDC-funded projects has policy implications. **Mr. Fine** answered that they had conducted a focus group with CDC-funded projects.

**Dr. Greenspan** said that as the policy framework moves toward more actionable items, it could fit well with the science and practice agendas. Policy can then be an integral part of decisions and can connect to ongoing research and evaluation that is needed.

**Ms. Patterson** agreed and noted that the policy framework could become a section of the research-to-practice agenda as they hone in on priority areas.

**Dr. Grossman** asked what they meant by "toned down."

**Ms. Patterson** recalled that the NAP grants do not address policy because of Section 503, which is a section of CDC's appropriation that restricts funded programs from engaging in lobbying. This section has always been in place, but it now includes more specific definitions regarding what constitutes lobbying. Not only are there questions regarding what they are legally able to say, but also there are questions regarding what is advisable to say. This document will serve as a framework and good guidance for how to engage in policy, but will not provide too much specific guidance or direction. For instance, rather than advising that states should implement primary seatbelt laws, the document might state that the evidence supports that primary seatbelt laws are the most effective way to reduce deaths from motor vehicle injury crashes.

**Dr. Grossman** thought it would be helpful to have a mechanism of policy analysis that would help the field understand the policy gaps. **Ms. Patterson** said that they could identify policy-related needs for their focus areas.

**Dr. Fowler** suggested that this framework could serve as a central piece with a general approach, but the development process would include an intentional plan that other entities will develop satellites to it. The satellites could be issue-specific policies or could address how to conduct strategic convening.

**Ms. Patterson** said that the current cycle of the Core VIPP funding announcement includes specific guidance on policy. They can consider where to incorporate policy into funding announcements so that they can work appropriately in policy. She hoped to help people not feel hesitant about policy and to understand that everyone has a role to play in policy so that everyone can work together appropriately to achieve mutual goals.

**Dr. Nation** commented that the framework is good, but it assumes that policy is always a rational process, when many times it is not. He has seen people miss opportunities to have impact as they collect data and gather stakeholders for conversations while other people are making decisions "behind closed doors." He hoped for a way to help people understand that they should take advantage of windows of opportunity, even as they engage in processes that may take longer.

**Ms. Patterson** agreed with Dr. Nation's comment. Dr. Fowler's idea about other entities creating "satellites" to the framework could address the issue. Solving problems requires data, the solution to the problem, and political will. Data and solutions should be ready for the time that political will is in place. She did not want to give the impression that a simple set of steps will lead to policy change. They can address these points through training, and they can also think about organizations that would contribute a "satellite" to the framework that addresses relationship-building and building trust with people who can champion the cause.

**Dr. Fowler** said that some of those documents already exist and could be intentionally unified. Regarding the question about three overarching priorities that could be used to advance the field of injury and violence prevention policy, **Mr. Fine** offered the example of APHA's three priorities: eliminating disparities, strengthening the public health infrastructure, and increasing access to care. All of their activities fall under the purview of one of those priorities. If injury and violence prevention were to adopt a similar model, what would those priorities be?

**Dr. Degutis** commented on the development of APHA's priorities. APHA includes 24 sections and other groups with their own agendas. Each section and group wanted APHA to advocate for their topic of interest. The organization had no unified way to move forward, so the concept of the three overarching priorities, which are consistent from year to year, ensures that members of APHA can talk about priorities and use concrete examples of their own work to illustrate needs and issues. The terminology and messaging are consistent. The injury field faces similar problems, as the field includes a diverse range of goals, priorities, and issues. Having three consistent priorities is ideal, as three priorities are not difficult to remember and the messaging remains constant from year to year. APHA's strategies have been in place since 2006.

**Ms. Patterson** commented that the priorities predate the ACA. **Dr. Degutis** agreed and noted that APHA hoped to influence health reform. They also hoped to alter the dialogue from a focus on healthcare to a focus on health systems and wellness.

**Dr. Fowler** asked whether the conversation about three injury and violence prevention priorities should take place in a national forum, when many people from the field assemble. The national Safe States / SAVIR meeting includes researchers, practitioners, and CDC grantees, and could include others as well.

**Dr. Degutis** said that they could begin to compile a list of suggested priorities and discuss what they could mean to the field, emphasizing that there is potential to have additional discussions at the Safe States / SAVIR conference in June.

**Dr. Linares** suggested that the priorities could include "keep us safe" and "keep us thriving." Safety refers to safety from direct injury, but "thriving" means that people should not only be free from mental or physical injury, but they should also thrive. The priorities should embrace child health and family health, or the "us."

**Dr. Degutis** added that the priorities should be visionary. "Thriving" is much more than just "existing."

**Dr. Fowler** asked whether a representative from APHA having a conversation about research, surveillance and evidence would incorporate infrastructure into the conversation. **Mr. Fine** said that the conversation could include infrastructure as well as workforce.

As there was no further discussion, **Dr. Fowler** conducted the day's final roll call. She established that a quorum remained and adjourned the meeting for the day at 4:19 pm.

**October 19, 2012****Opening / Roll Call**

**Carolyn J. Cumpsty Fowler, PhD, MPH**  
**Assistant Professor, Johns Hopkins University**  
**School of Nursing and Bloomberg School of Public Health**

**Dr. Fowler** called the second day of the 10<sup>th</sup> meeting of the NCIPC Board of Scientific Counselors to order at 8:38 am on Friday, October 19, 2012. A roll call was conducted of BSC members, which established that there was a quorum. Dr. Fowler reminded BSC members joining the meeting via teleconference to send an email to the program confirming their presence on the call.

**Global Activities at NCIPC**

**Susan Hillis, PhD**  
**Acting Senior Advisor for Global Health**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Linda C. Degutis, DrPH, MSN**  
**Director, National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Susan Hillis** presented the BSC with an overview of NCIPC's global activities in unintentional injury prevention and violence prevention. She reported that the thrust of NCIPC's global activities has been "How to Save One Million Lives a Year." Traffic injuries are an enormous global health problem. Decreasing motor vehicle injuries and fatalities is one of CDC's global Winnable Battles. Global traffic fatalities are equivalent to worldwide tuberculosis (TB) deaths and exceed malaria deaths. By 2030, traffic deaths will eclipse HIV deaths.

NCIPC has been highly involved with the UN in working on the Global Plan for the Decade of Action for Road Safety. This plan has the potential to decrease mortality by 50%, saving five million lives over the next ten years. Gaps remain in the area of road traffic injury prevention, including inaccurate data on the magnitude of the problem; inadequate use of evidence-based practices; inadequate evaluation of prevention efforts; and limited awareness among policy makers, donors, and the public.

NCIPC has been directly involved in several countries that CDC considers to be high priority. Specific activities are on-going in Thailand, Cambodia, Botswana, Uganda, China, and Peru. The work focuses on strengthening the Decade of Action activities, strengthening surveillance, increasing capacity-building and providing technical assistance, and evaluating taxes or limitation of alcohol consumption. NCIPC has also conducted significant global work in violence against children. These activities are increasingly relevant to HIV prevention. HIV rates in girls exceed rates in boys, especially in low- and middle-income countries. Reducing violence and

other structural determinants of health will lead to significant reductions in expected new cases of HIV infection.

NCIPC has completed Violence Against Children Surveys (VACS) in several countries, including Swaziland, Tanzania, Kenya, Zimbabwe, and Haiti. The surveys measure physical, emotional, and sexual violence. The center will enter the field in Cambodia, Indonesia, The Philippines, and Malawi in the next year. Several other countries, including Lesotho, Zambia, Nigeria, Vietnam, Laos, and Malaysia, have requested NCIPC's assistance in addressing violence against children. At the beginning of the VACS planning process, NCIPC elicits partnerships with major ministries, UN agencies, and NGOs in each country. The survey work does not proceed if the appropriate partnerships are not in place. If a country is interested in conducting the survey but is not interested in acting on the results, then it is neither wise nor ethical for NCIPC to proceed with the survey. In every country except Haiti in which the surveys have been conducted, rates of sexual violence among girls are approximately double the rates among boys. Typically, 3 out of 10 young girls have been sexually abused before the age of 18. In Haiti, rates among girls and boys are approximately equal.

Tanzania and Swaziland, the two countries that have publicly reported their VACS results, have responded to the surveys with policies and programs, including interventions at the individual, relationship, community, and societal levels. In the future, NCIPC will assist countries in leveraging VACS to increase resources to change programs and policies through HIV activities within governments. USAID is leading a multi-agency initiative called Protecting the Future for Children Living in Adversity. Reducing violence is one of the initiative's main objectives, and NCIPC is advising USAID in that area. NCIPC aims to expand public and private collaborations to continue this global work in the coming years.

**Dr. Degutis** asked for the BSC's input regarding how to position NCIPC to increase its visibility and impact on motor vehicle fatalities, which are a leading cause of death and a global burden. The funds that NCIPC uses for its global activities do not come from appropriations, but primarily are from foundations and other private sources. As an agency, CDC has set global work as a priority. CDC works extensively with WHO, and Dr. Degutis asked the BSC for suggestions for other potential partners for global work. Regarding unintentional injuries, she asked about other aspects of global disease burden, such as drowning in children, which should be prioritized. NCIPC is also working with WHO on a global report on suicide. NCIPC is one of the partners hosting the World Safety Conference in Atlanta, Georgia in October 2014. Hosting the conference, which focuses on injury and violence prevention, is an opportunity to drive the direction of global work. The conference has not been held in the US since 1993. Approximately 2000 people will attend the conference, satellite meetings, and activities.

### **Discussion Points**

**Dr. Feucht** asked about contributing factors to traffic deaths, such as alcohol consumption, a lack of highway markings and guardians, and other factors.

**Dr. Degutis** answered that a range of factors affect traffic deaths, and the factors depend upon the country. Lower- and middle-income countries face issues of infrastructure for highways and roads. Often, lane markers and barriers are absent. Pedestrian deaths occur because there are no safe places to walk. Traffic law enforcement is another concern. Some traffic laws may exist, but are not adequate to protect road users, pedestrians, and bicyclists. Regulation of vehicles is another concern in many countries.

**Dr. Li** referred to the NCIPC's article in the *Journal of Safety Research*, which outlines five strategic initiatives, including raising awareness of injury and violence, seeking out partnerships, and promoting evidence-based programs. He asked how NCIPC reacts to countries that are not interested in, or not responsive to, its initiatives. These countries could need expertise and evidence-based initiatives.

**Dr. Degutis** answered that NCIPC cannot force countries to accept its expertise or programs. Cooperation in-country is essential to any initiative. NCIPC receives many requests for help and consultation. For instance, a group from Taiwan interested in creating hospital-based injury surveillance system visited CDC. Other requests have come from Trinidad and Peru, and NCIPC staff will visit those countries in December 2012. NCIPC has limited funds to respond to these requests.

**Dr. Hillis** added that CDC has identified eight priority countries in which the agency focuses on non-communicable disease activities. NCIPC works in these countries in unintentional injury activities. CDC has identified 88 high-priority HIV countries and recognizes the importance of violence prevention activities in those countries.

**Dr. Li** commented on partnering with foundations such as the Robert Wood Johnson (RWJ) Foundation. He noted that the Bill and Melinda Gates Foundation conducts a great deal of work in international infectious disease and has recently released an annual report titled *Building Better Lives Together*.

**Dr. Degutis** replied that each foundation focuses on priority areas, and it is difficult to convince them to support initiatives outside their priority areas. For instance, RWJ only funds domestic work, and the Gates Foundation focuses on infectious disease. NCIPC cannot directly ask foundations for funding.

**Dr. Fowler** said that the Bloomberg Foundation is supporting international road traffic safety efforts. She commented on linking people at international companies who are interested in occupational health and safety and their concern about their employees to road traffic safety.

**Ms. Castillo** added that NIOSH and NCIPC work closely on the motor vehicle Winnable Battles.

**Dr. Greenspan** said that NCIPC is engaged in a collaboration in India that focuses on fleet safety. The work includes driver safety as well as encouraging businesses to review their policies regarding safe driving, such as the number of hours that truck drivers work and vehicle safety issues.

**Dr. Grossman** asked about CDC's involvement in the broad-based Global Road Safety Partnership and the Make Roads Safe campaign.

**Dr. Baldwin** said that CDC is part of the Global Road Safety Partnership through Dr. David Sleet's active engagement. CDC also has strong ties to the Make Roads Safe campaign. He noted that the Bloomberg Foundation has invested \$125 million in global road safety.

**Dr. Linares** asked about the process by which a country requests assistance from NCIPC and about the commitment that NCIPC secures from government agencies and academia in-country. Some countries may not have significant financial resources, but they may have human resources that can contribute to partnerships and activities.

**Dr. Hillis** answered that when a country requests assistance with the VACS, CDC conducts an initial three-day visit. The visit includes an overview of the survey and includes relevant ministries and relevant United Nations Children's Fund (UNICEF) and other UN agencies. VACS has been successful because links to activities from the beginning of the process. The human resources in countries have been impressive. For instance, when Tanzania released the data from its VACS, they also released a National Action Plan for Reducing Violence. The plan represents a collaboration across ministries.

**Dr. Baldwin** added that NCIPC's global engagements are tied to domestic benefits. It can be a challenge to make these connections, especially in a resource-constrained environment.

**Dr. Nation** asked about the types of violence prevention interventions that could achieve results in HIV prevalence, and about specific interventions and expected results that NCIPC can recommend to countries.

**Dr. Hillis** said that data are available for sub-Saharan countries regarding the impact of pairing Household Economic Strengthening (HES) with family strengthening. *Families Matter!* is a program that has been evaluated in randomized trials in the US and in several African countries. It shows significant impact on reducing risk behaviors in children. The results appear to be sustainable for 12 to 24 months. The Protecting the Future Initiative will adapt, test, and evaluate combined interventions in countries hardest impacted by the HIV and violence epidemics. Swaziland has a seroprevalence of 34%, which is the highest in the world, as well as a high prevalence of girls experiencing sexual violence before the age of 18 (37%). Swaziland has been conscientious about making a difference in both areas. Making positive changes requires multi-sector activities, and NCIPC is skilled at motivating and inspiring multi-sector efforts.

**Dr. Annest** described NCIPC's involvement in the development of International Classification of Disease (ICD)-11. NCIPC has worked on developing the external cause of injury element of ICD-11. Debates regarding changes in ICD-11 included the possibility of changing the coding to enable linking all mechanisms with intent of injury. In ICD-10, intent is coded first and then mechanism is coded. The number of mechanisms represented in some of the intents is not inclusive of all mechanisms. Suicide prevention professionals expressed concern that the changes might cause problems internationally, so intent will be coded first, and then mechanism, in ICD-11. Additionally, ICD-11 will be compatible with ICD-10 and will provide different formats. For instance, low-resource countries will utilize a minimum, or compressed, code set. Researchers will utilize an extended code set that will capture intent, mechanism, place of occurrence, activity, object, and substance. The choices in types of coding will be useful for the field.

**Dr. Baldwin** said that NCIPC is meeting with the United Parcel Service (UPS) Foundation, which reached out to them through the CDC Foundation. UPS is interested in evaluating their Road Code program, which is an international program that educates teen drivers about safe driving. This potential collaboration is a good example of a public-private partnership.

**Dr. Fowler** recalled a panel of former NCIPC directors at a recent Safe States / SAVIR meeting. The audience did not respond favorably to the discussion of NCIPC increasing its global reach. She asked how NCIPC uses lessons learned and evaluations from global work to strengthen the practice community in the US. For instance, demonstrating the impact of strategic collaboration internationally could move the US forward.

**Dr. Degutis** replied that as an agency, CDC responds to questions about its investments in global work. Global work must be linked to domestic work if appropriated funds are utilized. Global work represents an opportunity to learn about cultural differences, and it also can present opportunities to test interventions that would be difficult to test in the US. Working with agencies and understanding politics in other countries can be challenging, as it is in the US. She reiterated that if the center or the agency engages in global work that does not directly tie to domestic work, the funds are not from appropriations for domestic work. CDC leadership recognizes that global events affect the US economically and in other ways. Traffic-related deaths are the leading cause of death for healthy US citizens who travel outside the country. The agency is also concerned about emerging infections and viruses that could be brought into the US. Violence is a global concern that informs domestic work. Health is global.

**Dr. Spivak** commented that a growing number of programs are being developed in other countries, particularly in youth violence prevention. These programs are not only relevant to domestic programs, but could also be translated into projects in the US. The “two-way street” is relevant.

**Dr. Fowler** said that the field understands that domestic money is not being spent on global projects. Rather, it is important for NCIPC to identify the lessons learned in global work and to frame those lessons in communications to the injury prevention community.

**Dr. Baldwin** said that NCIPC can also learn a great deal from high-income countries. He pointed out that in many of their global engagements, NCIPC works with US-based multinational companies and supports their global footprint.

Regarding the upcoming World Safety Conference, **Dr. Fowler** hoped for the opportunity to conduct core competency training. WHO launched an online violence injury prevention program called TEACH-VIP. The pilot process for the program included an audience of law enforcement professionals in Oklahoma. They were enthusiastic about the violence against women module, because it enlightened them about international cultural issues. The conference could include international peer training opportunities.

**Dr. Hillis** said that the International AIDS Meeting is structured by two separate tracks. One track focuses on policy and program, and the other focuses on capacity-building. All attendees are together for plenary sessions and then attend breakout sessions according to their tracks.

**Dr. Baldwin** noted that the US culture focuses on “toward zero deaths,” while other developed countries have stronger safety cultures. Drs. Frieden and Degutis are interested in normative expectations and expectancies.

**Dr. Spivak** said that based on his experience at the conference in New Zealand, the presence of intentional injury and violence work has been limited. He hoped that the work would be elevated.

**Dr. Degutis** acknowledged that violence has been more visible in other world conferences. The conference in New Zealand reflected a bias toward New Zealand and Australia. In their conference planning, they will be cautious not to be too “US-centric.”

**Ms. Castillo** indicated that NIOSH convenes an International Occupational Injury Symposium every three years, which will be held in October 2014. There may be opportunities to collaborate on content. **Dr. Degutis** said that NCIPC would be happy to collaborate.

**Dr. Fowler** observed that the BSC does not include representation from a senior person in occupational safety, perhaps from a multinational company. An advisory partnership with such a representative could help them understand public-private international safety issues, particularly given NCIPC's global work.

**Dr. Degutis** agreed and added that the CDC Foundation convenes a group of global business leaders on a regular basis. One of the leaders has been a strong champion of Together For Girls, and NCIPC can use them as a resource.

With that, **Dr. Fowler** closed the session and dismissed the group for a break at 9:34 am. She called the group back to order and established that there was a quorum at 10:08 am.

## 20<sup>th</sup> Anniversary Activities

**Linda C. Degutis, DrPH, MSN**  
**Director, National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Dr. Degutis** described a number of activities associated with the 20<sup>th</sup> anniversary of NCIPC. NCIPC staff members have served as keynote speakers at professional meetings to gain more exposure for the center and its work. A logo and tagline "Celebrating the Past, Protecting the Future" also celebrate the anniversary. Additional information and materials, including videos, can be accessed at <http://www.cdc.gov/injury/anniversary>.

NCIPC created a "20 for 20" list to recognize people who have been major contributors or who have helped to shape the field of injury and violence prevention and to move it forward. The "20 for 20" will be recognized at the Injury Section of the APHA meeting in October 2012. In the spring of 2012, Safe States held their annual meeting in Atlanta and hosted a dinner to celebrate the 20<sup>th</sup> anniversary of NCIPC.

Another part of the celebration included a video contest entitled *Seeing My World Through A Safer Lens*. The contest was divided into the categories of professional, student, and general public. Winners in each category received a \$500 prize. The professional winner was the Iowa ICRC with "Safety Begins With You," the student winner was a video titled "Protect Your Brain, Wear a Helmet," and the winning video in the general public category was "Things Men Say To Men Who Say Things On the Streets." The videos are available on YouTube and on CDC's public website.

NCIPC also created a promotional toolkit for partners to utilize to talk about injury and violence prevention and about the Injury Center itself. The kit includes talking points, tools for working with the media, ideas for promoting the 20<sup>th</sup> anniversary, and a list of events and activities. Additionally, NCIPC staff have held Congressional briefings in conjunction with the anniversary. The year began with a slide show presentation, continued with a speaker series at CDC, and will culminate in a final celebration at CDC. The communications staff of NCIPC has worked with other staff from NCIPC and CDC, and the anniversary celebrations have been successful. They have considered the events not only to celebrate NCIPC, but also to celebrate the entire field of injury and violence prevention.

Dr. Degutis requested BSC input regarding how to continue to build visibility for NCIPC and for violence and injury prevention overall.

### **Discussion Points**

**Dr. Fowler** asked about plans to gather oral histories from the honorees on the “20 for 20” list.

**Dr. Degutis** answered that the list is an opportunity to document the history of the field. Some suggestions for capturing the leaders’ stories include creating a “Hall of Fame” of violence and injury prevention and to continue adding to the list of people who have made significant contributions to the field. NCIPC is considering the most meaningful way to proceed with this idea, perhaps by building a website to include oral histories and video clips to build awareness. A “Hall of Fame” could inspire students and people who are new to the field. Many careers in violence and injury prevention began when a person’s concern about one issue brought them to the field. NCIPC and Safe States have both engaged in a project called “Why You Do What You Do,” which encourages people to talk about their work and what it means.

**Dr. Li** asked whether the anniversary celebrations include highlighting research that NCIPC has funded that has made an impact on the field.

**Dr. Degutis** answered that the November issue of the *Journal of Safety Research* is devoted to a number of papers on injury and work that has been seminal in the field.

**Dr. Baldwin** added that the issue includes 18 papers addressing an overview of NCIPC and its history, where the center is going, research, practice, policy, motor vehicle injuries, poisoning and drug overdoses, violence against children and youth, TBI, global initiatives, two article reprints, two lectures from the anniversary lecture series, stories from the field and past directors, and CDC resources.

**Ms. Patterson** said that the Policy Office has conducted legislative outreach planning meetings with each division in the center. These meetings emphasize the need to highlight extramural research. Because of the “firewall” between the extramural research and the division, they are making a concerted effort to do a better job of incorporating that research into Congressional briefings so that information is available on activities in individual states.

**Dr. Cattledge** added that NCIPC is hosting a panel at the APHA conference on October 29, 2012 from 12:30 pm to 2:00 pm. Dr. Stephen Hargarten will discuss his research in the area of violence, and one of his community partners will discuss the translation from research to practice. Additionally, Sue Gallagher will discuss her experience in injury and her work in collaboration with NCIPC over the years.

Given that the goal of the anniversary activities is to raise visibility, **Dr. Fowler** asked about the purpose of the visibility, and with whom greater visibility is expected.

**Dr. Degutis** said that one of the center's goals is to elevate NCIPC's visibility within the field of public health. Many people within the field do not understand that violence and injury prevention are core components of public health and are as important as immunization or any other public health initiative. The NCIPC communications staff created an infographic to illustrate the relative burden of injuries and injury-related deaths. NCIPC also hopes to increase visibility among the general public, which does not embrace prevention as a concept. One of their strategies is to speak more boldly about what they do, their successes, and the importance of work in violence and injury prevention. Using the data in different ways will help people understand the burden and the nature of injuries and violence. In this arena, the center has worked on how to tell stories that illustrate the data, the components of a good story, and how to use stories to help people understand violence and injury prevention and what it means. Some partners have also taken on the storytelling initiative. The Safe States meeting included training on storytelling for state and local partners so that they can share their findings. It is difficult to measure success, but Dr. Degutis sensed that people are receiving the messaging.

**Dr. Borkowski** asked whether NCIPC had contacted present and past stakeholders, such as PIs, grant recipients, and grant reviewers. For instance, it would be relatively easy to contact grant reviewers with a thank-you note for their participation and a packet of information to share.

**Dr. Degutis** said that the center had not distributed information in that way and thanked him for the idea.

**Dr. Prothrow-Stith** suggested that developing the lay constituency could also increase visibility. The injury field has not successfully reached out to, and organized, its consumer groups. In the area of violence, these groups are often comprised of people who have experienced violence themselves, or violence toward a loved one.

**Dr. Degutis** said that groups are well-established in certain areas, such as brain injury, spinal cord injury, homicide, and suicide prevention. It is a challenge to coalesce those groups and it is also a challenge to convince the public that they and their families are at risk for being injured.

**Dr. Fowler** said that advocates and groups frequently hold awareness campaigns or health events, which are impressive and cathartic, but which are not evidence-based. In contrast, some advocates' work has led to changes in manufacturing standards in cars and the development of the International Road Safety Association (IRSA). Some survivors may have an urge to do something, but may not know what to do. It would be useful to identify effective survivor advocates and learn what they did, how they did it, and whom they partnered with to tell their stories and to build capacity in other survivor advocates. For example, a mother who lost her child in a strangulation event focused on supporting the Child Death Review (CDR) and an inter-professional understanding of why children die.

**Dr. Degutis** noted that SAMHSA has funded the Trauma Survivors' Network (TSN). The network was created to support survivors through their journeys and also to support advocacy. Many survivor groups argue for resources and access, not for prevention. The arguments for resources and access do not reach people who are at risk of different kinds of injury and violence.

**Dr. Fowler** recalled an APHA advocacy training session that focused not on direct survivors of injury, but on people who survived the death of another person and the consequences of failing to prevent injury or violence.

**Dr. Prothrow-Stith** said that many survivors find that helping others is part of the healing process.

As there was no further discussion, **Dr. Fowler** closed the session and dismissed the group for a brief break at 10:43 am. The meeting resumed at 10:52 am, at which time a quorum was confirmed.

## Communications: Where Are We Going?

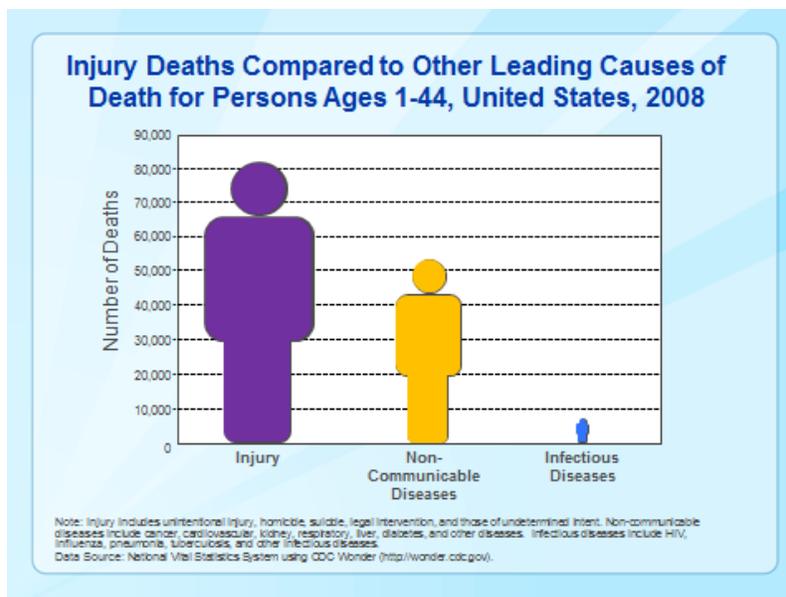
**Erin Connelly**  
**Acting Associate Director for Communication**  
**National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

**Ms. Erin Connelly** reported that is in the midst of a portfolio review of its Health Communication Science and Health Communication programs. The Communication Office is also working on other initiatives. She explained that the Plain Writing Act of 2010 requires executive agencies to use plain language in all documents and communications for the general public by October 2011. The compliance effort at NCIPC is widespread, and the communication staff has conducted trainings in several areas. Plain language is communication that an audience can understand the first time they read or hear the material. Audiences should be able to find the information that they need, understand the information that they find, and use the information to meet their needs.

NCIPC's communication staff has focused on branding implementation. Implementing the brand identity will define what the center is, what partners and stakeholders should know about the center, and how partners and stakeholders should perceive the center. Branding represents NCIPC's organizational "soul" and reputation. The three themes of the branding are: Influential Leadership; Science to Action; and Safer People, Safer World.

The third pillar of the communication staff's work is storytelling. Awareness of the importance of storytelling is high at NCIPC and among partners. There has been some confusion regarding the difference between storytelling, good oral presentation skills, and sharing programmatic success stories. The Communication Office of NCIPC aims to use plain language to share common messages and themes as well as compelling stories to move from information dissemination to true, effective communication.

Infographics are important tools in communication. Infographics convey context and meaning to deliver information and data in a more rich format than a static graphic. Ms. Connelly shared the following infographic that was developed to illustrate the burden of injury deaths in the US:



CDC Director Dr. Frieden implemented *Vital Signs*, a monthly publication that accompanies a scientific article in the *Morbidity and Mortality Weekly Report (MMWR)*. *Vital Signs* includes consumer-friendly products, such as fact sheets. The fact sheets utilize infographics to convey information, often about complex topics, effectively. It is important to ensure that infographics are useful for multiple electronic formats.

### **Discussion Points**

**Dr. Fowler** indicated that the BSC would like to be involved in the planning of NCIPC's portfolio reviews, including the purpose, focus, and value of the reviews. Ideally, the BSC could be included at the beginning of the process as well as at the end of the process.

**Dr. Greenspan** replied that NCIPC shared, and asked for comments on, the questions that the communications portfolio review would address. It is not clear how the BSC's feedback can best be incorporated into the review process.

**Dr. Fowler** said that many BSC members have been part of the portfolio review process. It is important to think critically about what NCIPC will do with the results of the reviews.

**Dr. Linares** asked about upcoming portfolio reviews.

**Dr. Greenspan** said that the BSC is part of the final stages of portfolio reviews, and some BSC members have been involved in the external review portion of the process. The process can take more than a year, utilizing a contractor and with a great deal of internal effort.

**Dr. Fowler** said that if NCIPC invests a great deal of time and effort into the portfolio reviews, then the reviews should work for the center beyond a basic level.

**Dr. Greenspan** said that the portfolio review process has been evolving for NCIPC. The ICRC and the Core VIPP portfolio reviews led to changes in FOAs and rethinking about projects. The center takes the reviews seriously and reports their results to the Associate Director for Science of CDC, including the results, recommendations, and the center's responses and actions.

**Ms. Connelly** said that the communications portfolio review has been challenging because the review is not considering a discrete program, but health communication as a function across NCIPC. The center communicates in a variety of ways and across many programs. The effort is groundbreaking for CDC, as no other health communications activities across the agency have engaged in a portfolio review. Because the function is large and draws upon a number of communications disciplines, they are learning how to focus their questions. The workgroup has created draft products that will comprehensively assess the breadth and scope of NCIPC's communications activities. Some of their lessons learned informed the reorganization of the center. The information is also helping them implement the new structure.

**Dr. Greenspan** added that this review represents the first review that cuts across all of the center's divisions. The process has been challenging, but informative. Competing demands have also been challenging.

Regarding infographics, **Dr. Fowler** commented that graphics are often reproduced and shared in black-and-white in resource-poor environments. She expressed her hope that the colorful graphics would still be readable and have impact in grayscale.

**Ms. Connelly** said that the infographics are designed primarily for digital communications, but recognized that it would be helpful to have versions that can be executed in print.

**Dr. Baldwin** emphasized that NCIPC has been at the forefront of the "infographic revolution" at CDC.

**Ms. Connelly** asked the BSC whether they are using plain language to communicate in their arenas. The communication staff struggles with the challenge of making sentences shorter and simpler while ensuring that they are still scientifically accurate.

**Dr. Linares** said that in her work with low-income populations, she struggles with implementation of evidence-based programs and classes. Some of the concepts in these programs are difficult to translate. She agreed that information and concepts should be clear to audiences the first time that they hear it. Programs that are disseminated should be in language that people understand. The issue is more complicated than translation to another language, but incorporates capturing ideas and experiences. She offered the example of a program that focuses on first changing behavior, and then changing attitude. Class leaders encourage parents to "fake it until you get it," which is a relatable and accessible message. She and her colleagues spend a great deal of time ensuring that families in their programs understand the messages in their programs.

**Dr. Nation** said that he and his colleagues approach the problem slightly differently. His work focuses on teachers and administrators. For everything that his group publishes, they also produce a policy brief in layperson's language that describes the problem, the results of the research, and the implications that the results might have for the audience. They attend to the language and the issues that the audience contends with in their work. For instance, the communications use similar terminology and metrics by which the audience will be evaluated and integrate those factors into their analyses.

**Dr. Li** said that he and his group spend a great deal of time on informed consent materials, which are produced at an eighth-grade reading level. They conduct focus groups that include a spectrum of educational levels. Most of his work focuses on senior populations. He asked whether NCIPC's communication materials are available in multiple languages for different communities and populations with different characteristics.

**Ms. Connelly** replied that specific campaigns and initiatives targeting specific behaviors in specific audiences do generate materials in multiple languages. Communication at the center level is generally not in multiple languages, and the center could be more aware of making information available in that manner.

**Dr. Borkowski** said that his approach is not to begin the intervention immediately after the informed consent process, but rather to show a video of a person who has been through the intervention. This video sets the stage for plain language that is easily understood. There is a motivational factor related to the reception or comprehension of messages. Plain language may be used, but the person may not want to hear the message. Beginning with a story sets the stage for comprehension.

**Dr. Fowler** expressed concern that a focus on plain language may detract from a focus on the right messages and information to share. Are they communicating science in plain language, or are they communicating the "so what" in plain language? Focusing on the means of plain language may detract from the desired end result of the communication. A message could be in plain language, but if the audience does not want to hear the message, then it will not be effective. As NCIPC develops its expertise in this area, the center could benefit the field by creating effective injury prevention messaging rather than "shoving injury prevention science down people's throats."

**Ms. Patterson** described the Policy Impact Series, a series of booklets on policy issues in prescription drug and motor vehicle areas. That series and *Vital Signs* are effective at connecting the science to the different roles that different audiences can play in addressing the issues. *Vital Signs* is available at <http://www.cdc.gov/vitalsigns>.

**Dr. Fowler** wondered if there was a way for different audiences, such as medical providers or teenagers, to access what they can do about a problem or issue.

**Dr. Baldwin** agreed that there are different ways to share the material. In addition to framing messages correctly, NCIPC wants to ensure that the information is compelling and receives sustained attention. He noted that the materials are wordsmithed extensively.

**Dr. Fowler** observed that the messages are "short and sharp." She asked about the center's involvement in the mHealth Initiative.

**Dr. Baldwin** said that as a whole, CDC is making a broad investment in mobile communications. Advances in smart phone technologies bring great opportunities for market penetration.

**Ms. Connelly** said that the NCIPC Office of Communication has a detailed short-term person working in the office on digital communication and marketing. This person serves as a lead for the center website and also works in digital communication beyond a webpage and a Facebook page, finding effective channels for sharing information and content. Digital content strategy is

a science, and NCIPC recognizes that its website is its face, but it is important to stay ahead of the curve of digital channels.

**Dr. Spivak** added that the center has held a number of Twitter Town Halls. **Dr. Degutis** added that the center has participated in live Twitter chats with Dr. Richard Besser.

**Ms. Michelle Hutrick** (Communications Lead, DUIP, NCIPC) said that even when digital material is geared toward a certain audience, because the material is shared digitally, it is not possible to control who receives the messages. It is not always possible to achieve the nuance of an *MMWR* article in a fact sheet.

**Ms. Connelly** said involving the communications staff at the beginning of the process ensures that science and the “so what” work together and are effective from the outset.

**Dr. Baldwin** commented that in the *Vital Signs* on prescription drug overdose prevention, they struggled with the best terminology to use to describe opioid pain relievers, opioid prescription painkillers, and other variations. The right phrasing should resonate with the lay public but still be scientifically accurate.

**Ms. Connelly** asked the BSC if they were aware that NCIPC has changed its branding language. They have begun to implement the branding language in conjunction with CDC's 24/7 campaign, which focuses on protection.

**Dr. Fowler** said that she had seen the rebranding, but was not certain whether she had seen it outside of conferences.

**Ms. Connelly** asked the BSC whether they talk to other people about CDC, and how they describe CDC. Further, she asked the BSC whether partners and stakeholders have a role in conveying the brand.

**Dr. Linares** said that CDC website has a great deal of validity as a resource. **Ms. Connelly** agreed that the overall CDC brand is credible and trusted for data and science.

**Dr. Nation** added that CDC has a great deal of social capital among the general public and professional constituencies. Schools recognize CDC's important function through CSH and the Youth Risk Behavior Surveillance System (YRBSS). He did not have the sense that schools communicate directly with CDC or get information directly from the agency.

**Ms. Connelly** asked whether Dr. Nation's audiences identify CDC with injury and violence prevention. **Dr. Nation** replied that some schools identify CDC with violence prevention, but most schools see a broader health perspective for CDC.

**Ms. Castillo** noted that the responses from the BSC related to CDC rather than to the Injury Center.

**Dr. Li** said that when he works with groups of seniors, he is not likely to refer to CDC. When he works with healthcare professionals and clinicians, he refers to CDC in its capacity as a public health authority. Most people identify CDC with infectious disease rather than with injury and violence prevention.

**Dr. Fowler** said that the CDC brand depends on the audience. She frequently links to CDC documents and resources in her course websites. She also assigns students activities on the CDC website or using their smartphones to use CDC for information. When she works with injury prevention coordinators, EMS, and fire personnel in her state, she explains that CDC is a prevention partner that can provide data and materials for them to do their work in communities. She said that it would help states if presentations, templates, and talking points were available for download. In working with uniformed services such as police, fire, and EMS, she reminds them that CDC is the Public Health Service (PHS) is a uniformed service that fights issues with them. She recalled a battalion chief who referred to drunk driving as terrorism because it threatens safety.

**Dr. Degutis** said that it may not be possible to focus on CDC as a uniformed service because of other factors that may impact the Commission Corp.

Ms. Haegerich inquired as to whether the BSC members identify that they are working with the Injury Center or with CDC. She noted that NIH personnel and grantees usually refer to a specific institute within NIH and wondered whether NCIPC has a brand or perception that is broader than CDC.

**Dr. Li** and other BSC members indicated that they refer to CDC as a whole.

**Ms. Patterson** asked whether it is more important for NCIPC to build its own brand, or to focus on including injury and violence as part of CDC's brand, which is well-established.

**Dr. Fowler** recalled Dr. Degutis's comment that many people in public health do not understand why injury and violence are important in public health. Raising the visibility of NCIPC within CDC may be a way to help public health understand how injury and violence fit into the field.

**Ms. Connelly** said that CDC's Creative Services Division can serve as an "internal ad agency" that can create concepts and work directly with subject matter experts to generate creative ways to communicate different ideas. An infographic could be created to show how injury and violence are related to public health, for instance. She asked the BSC to discuss high-priority concepts or data points that would benefit from an infographic.

**Dr. Fowler** asked about evidence on the universality of the infographics across languages, cultures, and backgrounds. **Ms. Connelly** was not aware of the science, but she acknowledged that some symbols and images will translate better than others.

**Dr. Li** commented that virtual reality uses avatars, which are developed to have different sizes and characteristics.

**Ms. Castillo** said that the occupational field often relies on signage to communicate, and research has considered different types of signage and complexities. Distinct cultural issues do come into play, and the science base might be informative.

**Dr. Baldwin** asked about balancing the net gain of the accessibility of the infographic with potential cultural barriers.

**Dr. Spivak** said that some images may not only be misunderstood, but could also have negative connotations. The images do require some words, so translation is still an issue.

**Dr. Fowler** said that the goal is to use infographics expertly, but not to rely on them. As NCIPC develops expertise in communication, it will be useful to document their discussions and ideas to share things to think about in terms of using graphics and plain language.

**Ms. Connelly** asked the BSC members whether they tell stories when they make presentations, and whether the BSC members perceive that NCIPC tells stories.

**Dr. Fowler** commented that Dr. Degutis tells stories more now than she has in the past.

**Ms. Connelly** clarified that NCIPC uses stories in scientific presentations, but also across other communication modes, such as the Director's Blog. Stories are a "hook" with which NCIPC is becoming more comfortable at the individual level, as well as in digital communication products.

**Dr. Nation** said that he has heard stories, but he noted that he is an easy audience. He does not believe that communities hear the center's stories. Many communities would likely be interested in the stories if there was a forum in which to share them.

**Dr. Degutis** said that NCIPC is also encouraging bolder language in its communication. For example, "Injuries are the leading cause of death for persons between the ages of one and 44" is not as bold as, "Injuries kill more people than any other cause." She asked the BSC members whether they were hearing that terminology and wondered how best to encourage others in the field to use stronger terminology. The data behind the statements are the same, but the phrasing is different and not passive. Another goal of the shift in language is to present information in a different and interesting way and to highlight different issues. NCIPC is also moving toward not using slides at all in its talks.

**Dr. Linares** said that in terms of child maltreatment and violence, she battles the notion that "it's not about me." When people think that an issue is "not about me," they tune it out. Teen dating and violence and violence against women are about everyone, and messaging should be inclusive so that people cannot tune the messages out.

**Dr. Fowler** commented that while multimedia is perceived as chiefly visual, she has been surprised that her students frequently request podcasts or MP3s. Audiences listen to those materials while they are commuting or waiting in line, and they are not expensive to produce. She offered the example of Story Corps, which makes stories available for download.

**Dr. Li** supported the innovative technologies in communication, but he reminded NCIPC to consider senior populations, especially those in rural communities. The public health field works with these populations a great deal. Rural areas may have Internet access, but speeds are slow, making downloads difficult. Traditional approaches are appropriate for these groups.

**Dr. Degutis** said that one of the center's challenges is the government-wide shift to not printing and distributing materials.

**Dr. Fowler** asked Dr. Li whether his populations would be interested in, and responsive to, stories that were presented to them. **Dr. Li** clarified that he was concerned about how public health entities in rural areas can share information with their populations.

**Ms. Patterson** wondered whether the previous suggestion to make digital materials printable in place and white for easy distribution would be a workable solution.

**Dr. Spivak** pointed out that senior and rural populations may not utilize high-level technology, but they have social networks. The task may be to integrate messages within those social networks. For instance, if groups gather at a senior center, then information can be shared there in an entertaining way.

**Dr. Fowler** noted that there is a great deal of literature on using radio messaging. **Dr. Li** agreed that many of the populations with which he works listen to the radio, especially National Public Radio (NPR).

**Dr. Feucht** commented that videos are difficult to develop and produce, are sometimes difficult to download, and are not portable. In contrast, audio is easy to produce, and audiences can subscribe to podcasts. Regarding branding, he noted that “NCIPC is the CDC” in the crime and justice world.

As there were no additional comments, **Dr. Fowler** closed the session at 12:07 pm. At 12:42 pm, a quorum was confirmed and the next session began.



### Incorporating more Practice Input to the BSC

**Linda C. Degutis, DrPH, MSN**  
**Director, National Center for Injury Prevention and Control**  
**Centers for Disease Control and Prevention**

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

**Dr. Degutis** explained that prior to the establishment of the BSC, the Advisory Committee for Injury Prevention and Control (ACIPC) advised NCIPC. ACIPC included representatives from practice and scientists. NCIPC is focusing on an initiative to link practice and science and is considering how to make that connection at the advisory level. A separate group consisting of practitioners is not likely to achieve the goal of linking practice and science, given that they would not be part of the primary advisory group. She requested the BSC members' thoughts regarding how to incorporate people in the field who use science on a daily basis to influence their practice.

**Dr. Greenspan** added that the BSC's discussions had touched on how NCIPC can work more with the practice community and how to build an agenda around research-to-practice, how practice can inform research, and how to gather practice input. It is essential for NCIPC to hear greater input from the practice community in an inclusive and strategic manner.

## **Discussion Points**

**Dr. Linares** asked about the shortcomings of the ACIPC structure and how these could be improved upon.

**Dr. Degutis** said that a previous CDC Director moved the agency from advisory committees to a BSC structure. **Dr. Greenspan** added that the structure consisted of the ACIPC and a Scientific Review Subcommittee, which conducted secondary reviews.

**Ms. Castillo** reported that NIOSH has had a BSC for more than 20 years. Their board includes representatives from academia, employers and management, and unions. NIOSH does not use its BSC for secondary review of grant applications, but the BSC reviews programs and advises in other ways. Including practitioners is very helpful.

**Dr. Greenspan** indicated that the charter of the BSC stipulates that participants must have terminal degrees. That requirement excludes a large segment of the practice community.

**Ms. Castillo** said that most of the NIOSH BSC members have terminal degrees, but there are a few exceptions. The employer representation generally comes from medical officers who are responsible for occupational safety and health for large corporations.

**Dr. Cattledge** clarified that when the criteria for CDC BSCs became more stringent in 2005, NIOSH was probably grandfathered into the new structure.

**Dr. Fowler** asked what NCIPC means by “practitioner.”

**Dr. Degutis** answered that NCIPC hopes for representation from people who are on the program side of violence and injury prevention, such as a person from a Core VIPP Program or a STRYVE site. Representation from academics and research is strong, and although many research projects take place in real-world settings, people who implement the science and conduct the program work have little opportunity to inform NCIPC.

**Ms. Patterson** added that representation from the policy world might also be helpful. **Dr. Degutis** agreed, noting that policy is part of practice. Further, representation from the media or communications world could be very valuable to NCIPC. The committee should not be restricted to persons with terminal degrees who may not be “on the ground” in practice.

**Dr. Nation** observed that the BSC members support the idea of including the practice community in the advisory structure for NCIPC.

**Dr. Degutis** agreed, emphasizing that the challenge regards how best to incorporate practice into the structure. There could be opportunities to include survivors who may not have formal education degrees, but who have important experience and education in other areas. NCIPC must determine whether to change the fundamental structure of the advisory group and to create a new charter for a new group.

**Dr. Feucht** said that he and his colleagues at NIJ have wrestled with this question in several areas. In each case, they employed a hybrid, mixed-model to include practitioners, policymakers, and researchers. He is not convinced that the model works best. The information and questions that practitioners can provide are often different from information and

questions from other constituencies. There are reasons to bring practitioners and researchers together to create ideas, but the information from each group can be different.

**Dr. Degutis** asked whether any of the conversations at the BSC meeting thus far would lend themselves to having input from practitioners and researchers together.

**Dr. Feucht** envisioned practitioners in his field who would be comfortable in that setting. The interests and input from practitioners and researchers may or may not overlap.

**Dr. Fowler** asked about the possibility for flexibility beyond a single advisory committee. For instance, one committee with mixed membership could provide advice on general center issues, and an additional committee could focus on other issues, such as public-private partnership or translation.

**Dr. Degutis** said that they have options, but cost and staff time are significant concerns. Each advisory committee must have a charter and a certain number of meetings, which has cost impacts.

**Dr. Fowler** said that when representatives were no longer included on ACIPC, companies were not willing to send representatives to a group that they perceived to be second-level. Representatives from academics may have similar concerns. She suggested creating a more informal advisory network with willing participants that may not require a charter and a large budget.

**Dr. Degutis** said that while she understood the suggestion, it did not address the issue of creating an official role for practitioners. This role should be equivalent to the role of scientists who provide advice to the center. It is important to CDC and Dr. Frieden to support state and local health departments and practice.

**Dr. Borkowski** said that the problem could be solved in phases. In the first phase, NCIPC could add two practitioners who are familiar with CDC to the BSC. Moving quickly and hearing their input is a good way to move to the next phase.

**Dr. Greenspan** noted that a package is now pending to add two practitioners with terminal degrees to the BSC. That step is temporary, and NCIPC recognizes the need to include more practice people, but the solution is not permanent because the BSC structure forces NCIPC to reach a small pool of practice people with terminal degrees.

**Ms. Patterson** asked about the possibility of breakout sessions or different groups that focus on different issues. Hearing the scientific community's input on policy and partnership issues is important, she added, and she hoped that they would not focus on one type of audience.

**Dr. Greenspan** agreed that the science community wants to hear from other audiences. Practitioners and policy people can help scientists determine what the science needs to be doing next.

**Dr. Feucht** indicated that NIH convenes strategic planning groups, which include persons from the practice community, to talk about general strategic next steps and gaps. These groups convene every year or two years rather than every six months. Guiding or informing programs is a slow process. His Federal Advisory Committee Act (FACA) group is considering creating ad hoc subcommittees. Other bodies create task forces that last for a brief period of time. The

governing body supplements itself from external individual who work on a topic under the banner of the larger body, so the work has importance and a sense of urgency.

**Dr. Degutis** said that people in practice are asking for “a seat at the same table as opposed an occasional discussion or participation on a subcommittee. They had this seat before the changes in the advisory committee structure.

**Dr. Nation** asked whether NCIPC has envisioned a structure for the group that might encourage the type of dialogue that would be helpful. For instance, would the group include representation from across the divisions of the center?

**Dr. Degutis** said that it is important that the group include people who think strategically and who have a global perspective. It is important that members do not dwell on a particular agenda or topic area, but contribute to the discussion as a whole and see different perspectives. NCIPC leadership is discussing how to nominate members to the BSC.

**Dr. Linares** stressed that it is important to include not only practitioners with terminal degrees, but also those with non-terminal-degrees. Practitioners with terminal degrees could serve in a “translator” role for researchers and practitioners. **Dr. Degutis** expressed her hope that the group would not be restricted to practitioners with a terminal degree.

**Dr. Fowler** suggested that NCIPC think about the criteria for both scientists and practitioners to be included on the advisory group. The current members of the BSC are actively engaged in the community. She inquired about CDC’s criteria for making appointments to advisory positions.

**Dr. Cattledge** responded that there are several factors besides the terminal degrees that are considered when a person is nominated for membership. However, we must remember that the approval of who actually becomes a member on the advisory boards is determined by HHS. **Dr. Greenspan** added that the guidelines address geographic, ethnic, and gender representation. NCIPC asks the divisions for recommendations, discusses them, and generates a list of possible members to vet with Dr. Degutis and present to CDC and HHS. She agreed that BSC members should think strategically and out of their area as well as in their area.

**Dr. Degutis** emphasized that BSC members should be willing to commit to attending meetings. She recognized that this meeting was not scheduled in a timely manner, and assured everyone that future meetings would be scheduled further in advance. However, BSC members who do not attend meetings are taking a spot that could be filled by a person who will contribute to the discussion. Lack of attendance at meetings is problematic, and people who are not committed should be asked to resign from the group so that someone else can be appointed.

**Dr. Greenspan** said that they would suggest definite dates and repeating time periods for regular BSC meetings. Schedules can be challenging, but sufficient lead time and regular, expected meetings should improve attendance.

**Dr. Fowler** asked whether practitioners have suggested ways to include their voices in advisory groups.

**Dr. Degutis** replied that practitioners would like to be part of the BSC or of a group that includes scientists. Practitioner involvement not only will benefit NCIPC, but also will aid in bringing the field together in partnerships.

**Dr. Fowler** stressed on the strategic importance of connecting to other areas of public health, such as chronic disease and aging. She asked whether NCIPC will include advisors who are familiar with injury, but who are connected with other areas.

**Dr. Degutis** replied that CDC directors are encouraging their BSC members to attend one another's meetings. They can learn a great deal from each other, and many issues cut across centers. She noted that the Office of Public Health Preparedness and Response (OPHPR) has a representative from RWJ on their BSC. If NCIPC expands the BSC membership, they can consider private sector representatives. Further, NCIPC frequently works with the other centers at CDC on crosscutting issues.

**Dr. Nation** attended the BSC meeting for the National Center of Environmental Health (NCEH) and found the experience to be interesting. At that meeting, a Committee on Community and Environmental Health discussed suicides involving hazmat materials, which have increased in recent years. NCIPC has experience and expertise so that they will not have to duplicate efforts.

**Dr. Degutis** said that NCIPC has worked with their counterparts in India regarding the use of pesticides for suicides.

**Dr. Nation** said that it was interesting to hear other ideas about surveillance and thinking strategically about distributing resources in order to make national-level statements.

### Public Comment Period

**Dr. Fowler** opened the floor for public comment at 1:23 pm. No public comments were made.

### Wrap-up, Roll Call, and Adjourn

**Carolyn J. Cumpsty Fowler, PhD, MPH**  
**Assistant Professor, Johns Hopkins University**  
**School of Nursing and Bloomberg School of Public Health**

**Dr. Fowler** thanked the NCIPC staff who organized the meeting, as well as the NCIPC staff who offered their support and contributions. The next BSC meeting will be scheduled for May or June 2013.

With no further business posed or comments / questions raised, the tenth meeting of the BSC was adjourned at 1:25 pm.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the October 18-19, 2012 NCIPC BSC are accurate and complete:

April 16, 2013

Date



Carolyn Cumpsty Fowler, Ph.D., M.P.H.  
Chairperson

**Attachment A: Meeting Participants****CDC Staff Present**

Lee Annest, PhD, MS  
Grant Baldwin, PhD, MPH  
Lisa Barrios, DrPH, ScM  
Jeneita Bell, MD  
Mark Biagioni, MPA  
Michele Brown  
Gwendolyn H. Cattledge, PhD, MSEH, FACE  
Erin Connelly, MPH  
Paige Cucchi,  
Linda Dahlberg, Ph.D  
Linda Degutis, DrPH, MSN  
Leslie Dorigo, MA  
James Enders, MPH  
Connie Ferdon, Ph.D  
Susanne Friesen,  
Curtis Florence, PhD  
Marquissette Glass, MA  
Arlene Greenspan, DrPH, MPH  
Julie Haarbauer-Krupa, PhD  
Tamara Haegerich, PhD  
Gail Hayes,  
Thadesse Haileyesus  
Jamyie Hickman  
Susan Hillis, PhD  
Daniel Holcomb  
Wendy Holmes MS  
Heidi Holt, MPA  
Michele Huitric, MPH  
Tochukwu Igbo,  
Lynn Jenkins, MA  
Renee Johnson, PhD  
Christopher Jones  
Lisa Kiser  
Marcie-jo Kresnow, MS  
Michele LaLand,  
Karen Ledford  
Tonia Lindley  
Lisa McGuire, PhD  
Gaya Myers, MPH  
Brandon Nesbit  
Rita Noonan, PhD  
Darryl Owens  
Nimeshkumar Patel,  
Sara Patterson, MA  
Chester Pogostin, DVM, MPA

Roberto Ruiz, MPA  
Thomas Simon,  
Paul Smutz, PhD  
Howard Spivak, MD  
Mary Stuckey  
Jane Suen, DrPH  
Sally Thigpen  
Karen Thomas  
Kevin Webb  
Natalie Wilkins  
Dionne Williams

**Others Present / Affiliations**

Kimberly Cleveland, CGMP, Project Director Seamon Corporation  
Kendra Cox, Writer / Editor, Cambridge Communications & Training Institute  
Jim Evans, AV, Sound on Site  
Stephanie Henry-Wallace, Writer / Editor, Cambridge Communications & Training Institute

## Attachment B: Acronyms Used in this Document

Acronym	Expansion
AAMC	Association of American Medical Colleges
AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACEP	American College of Emergency Physicians
ACES	Adverse Childhood Experience Study
ACF	Administration for Children and Families
ACIPC	Advisory Committee for Injury Prevention and Control
ACO	Accountable Care Organization
AMA	American Medical Association
AoA	Administration on Aging
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
BAA	Broad Agency Announcement
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CDR	Child Death Review
CGH	Center for Global Health
CMS	Centers for Medicare and Medicaid Services
CPSC	Consumer Product Safety Commission
CR	Continuing Resolution
CSH	Coordinated School Health
DARPI	Division of Analysis, Research, and Practice Integration
DASH	Division of Adolescent and School Health
DIR	Division of Injury Response
DOJ	Department of Justice
DUIP	Division of Unintentional Injury Prevention
DVP	Division of Violence Prevention
ED	(United States) Department of Education
EHR	Electronic Health Record
ERPO	Extramural Research Program Office
FACA	Federal Advisory Committee Act
FDA	(United States) Food and Drug Administration
FOA	Funding Opportunity Announcement
FY	Fiscal Year
HES	Household Economic Strengthening
HHS	(Department of) Health and Human Services
HIE	Health Insurance Exchange
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HUD	United States Department of Housing and Urban Development
ICD	International Classification of Disease
ICRC	Injury Control Research Center
IOM	Institute of Medicine
IPV	Intimate Partner Violence
IRSA	International Road Safety Association
IT	Information Technology
LISC	Local Initiatives Support Corporation
MCO	Managed Care Organization
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MOA	Memorandum of Agreement
NACCHO	National Association of County and City Health Officials
NAESP	National Association of Elementary School Principals
NAME	National Association of Medical Examiners
NAP	National Action Plan

Acronym	Expansion
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCIPC	National Center for Injury Prevention and Control
NGA	National Governors Association
NGO	non-governmental organization
NHSA	National Head Start Association
NHTSA	National Highway Traffic Safety Administration
NIJ	National Institute of Justice
NIMH	National Institute of Mental Health
NIOSH	National Institute for Occupational Safety and Health
NSC	National Safety Council
OADS	Office of the Associate Director for Science
OD	Office of the Director
OJJDP	Office of Juvenile Justice and Delinquency Prevention
ONDCP	Office of National Drug Control Policy
OPHPR	Office of Public Health Preparedness and Response
PDMP	Prescription Drug Monitoring Program
PHS	Public Health Service
PI	Principal Investigator
PPHF	Prevention and Public Health Fund
PRR	Patient Review and Restriction (Programs)
PTA	Parent Teacher Association
RFA	Request for Applications
RPE	Rape Prevention and Education (program)
RWJ	Robert Wood Johnson (Foundation)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAVIR	Society for the Advancement of Violence and Injury Research
SME	Subject Matter Expert
SSNR	Safe, Stable, and Nurturing Relationship
STEADI	Stopping Elderly Accidents, Deaths, and Injuries
STRYVE	Striving To Reduce Youth Violence Everywhere
SV	Sexual Violence
TB	Tuberculosis
TBI	Traumatic Brain Injury
TIIDE	Terrorism Injuries Information, Dissemination and Exchange
TSN	Trauma Survivors' Network
UN	United Nations
UNICEF	United Nations Children's Fund
UPS	United Parcel Service
US	United States
USAID	United States Agency for International Development
USPSTF	United States Preventive Services Task Force
VA	(United States) Department of Veterans Affairs
VACS	Violence Against Children Surveys
VAWA	Violence Against Women Act
VIPP	(Core State) Violence and Injury Prevention Program
WHO	World Health Organization
WISQARS	Web-based Injury Statistics Query and Reporting System
YRBSS	Youth Risk Behavior Surveillance System