

**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 Open Session



**Twelfth Meeting
November 15, 2013
Summary Report**

Table of Contents

Call to Order, Roll Call, Welcome, Introductions, and Announcements.....	3
Announcements	5
Approval of Last Meeting Minutes.....	7
Director’s Update	7
Health Communication Portfolio Review.....	12
Topic for the Next Portfolio Review.....	25
Public Comment Period	27
Conclusion and Adjourn.....	28
Certification	29
Attachment A: Acronyms Used in this Document	30

AGENDA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
BOARD OF SCIENTIFIC COUNSELORS (BSC)
Centers for Disease Control and Prevention (CDC)
Office of Non-Communicable Diseases, Injury, and Environmental Health (ONDIEH)
National Center for Injury Prevention and Control (NCIPC)
Twelfth Meeting

November 15, 2013
4770 Buford Highway
Chamblee Campus, Building 106, Conference Room 1B
(Teleconference Call)
Atlanta, Georgia 30341

Summary Proceedings

The twelfth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) was convened on Friday, November 15, 2013. Dr. Carolyn Cumpsty Fowler served as chair.



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 twelfth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) to order at 9:05 am on Friday, November 15, 2013. She thanked the BSC members for their time and commitment to injury and violence prevention, and reminded everyone that the role of the BSC is to provide advice to the leadership of NCIPC on its injury prevention and control research and activities. She noted that the predominance of the meeting would be comprised of a center update, a report on the health communication portfolio review, and a discussion of the next portfolio review topic. She emphasized that the meeting should be an informal exchange of ideas, questions, and feedback and welcomed participation and discussion throughout the meeting. Dr. Fowler then requested that Ms. Tonia Lindley call the roll to ascertain whether there was a quorum.

Ms. Tonia Lindley, Committee Management Specialist for NCIPC, conducted a roll call of BSC members and federal liaison representatives who were present in person and on the telephone. A quorum of BSC members was determined to be present, and a quorum was maintained throughout the meeting. She requested that those present send her a email to confirm their attendance at imx9@cdc.gov and that those in the room sign in using the book provided.

Dr. Fowler welcomed new member Dr. Sam Forjough to his first NCIPC BSC meeting, and requested that each member introduce him- or herself and state their name and affiliation. She also requested that to assist the writer/editor during the teleconference, individuals state their names prior to making comments throughout the meeting.

BSC Members Present (Via Teleconference)

- John G. Borkowski, MD, Developmental Psychologist, Professor, Department of Psychology, University of Notre Dame
- Carolyn J. Cumpsty Fowler, PhD, MPH, Assistant Professor, Johns Hopkins University School of Nursing and Bloomberg School of Public Health (Chair, BSC)
- Samuel Forjoug, MD, MPH, DrPH, FGCP, Department of Family and Community Medicine, Texas A&M Health Science Center College of Medicine
- Deborah Gorman-Smith, PhD, Chicago Center of Youth Violence, Chaplin Hill at University of Chicago
- Sherry Lynne Hamby, PhD, Department of Psychology, Sewanee The University of the South
- Stephen Hargarten, MD, MPH, Professor and Chair, Department of Emergency Medicine, Medical College of Wisconsin
- Robert L. Johnson, MD, Dean, University of Medicine and Dentistry, New Jersey Medical School
- Angela D. Mickalide, PhD, MCHES, Executive Director, Emergency Medical Services, Children's National Medical Center
- Sherry D. Molock, PhD, Associate Professor, Department of Psychology, George Washington University
- Maury Nation, PhD, Clinical Community Psychologist, Associate Professor, Department of Human and Organizational Development, Vanderbilt University
- Robert O'Connor, MD, Professor and Chair, Department of Emergency Medicine, University of Virginia
- Christina A. Porucznik, PhD, MSPH, Assistant Professor, Department of Family and Preventive Medicine, University of Utah
- Maria Testa, PhD, Senior Research Scientist, Research Institute on Addictions, University of Buffalo
- Shelly D. Timmons, MD, PhD, FACS, Director of Neurotrauma, Department of Neurosurgery, Geisinger Medical Center

Federal Liaisons Present (Via Teleconference)

- Dawn Castillo, MPH, Director, Division of Safety Research, National Institute for Occupational Safety and Health (NIOSH, Alternate)
- Lisa J. Colpe, PhD, MPH, Chief, Office of Clinical and Population Epidemiology Research, Division of Services and Intervention Research, National Institute of Mental Health (NIMH)
- Elizabeth A. Edgerton, MD, MPH, Branch Chief, EMSC and Injury Prevention, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA)
- Lyndon Joseph, PhD, Health Scientist Administrator, Division of Geriatrics and Clinical Gerontology, National Institute on Aging (NIA)
- Iris R. 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)

NCIPC Staff Present / Affiliation

- Grant Baldwin, PhD, MPH, Director, Division of Unintentional Injury Prevention (DUIP), NCIPC
- Gwendolyn H. Cattledge, PhD, MSEH, NCIPC Deputy Associate Director for Science, Designated Federal Official (DFO) for the NCIPC BSC
- Linda C. Degutis, DrPH, MSN, Director, National Center for Injury Prevention and Control
- Leslie Dorigo, Deputy, Office of Communications, NCIPC
- James A. Enders, Deputy Director Division of Analysis, Research, and Practice Integration (DARPI), NCIPC
- Arlene Greenspan, DrPH, MPH, PT, Acting Branch Chief, Health Systems and Trauma Systems Branch DARPI, NCIPC
- Tamara Haegerich, Deputy Associate Director for Science, Division of Unintentional Injury Prevention (DUIP), NCIPC
- Susan Hillis, PhD, Senior Advisor for Global Health, NCIPC
- Michele Huitric, MPH, Health Communications Lead,
- Renee Johnson, PhD, Senior Scientist, Core State Violence and Injury Prevention Program (Core VIPP), Division of Violence Prevention NCIPC
- Tonia Lindley, Committee Management Specialist for the NCIPC BSC
- Karen Mack, Ph.D, Associate Director for Science, Division of Analysis, Research, and Practice Integration (DARPI), NCIPC
- Jennifer Middlebrooks, MSW, MPH, Division of Analysis, Research, and Practice Integration (DARPI) , NCIPC
- Sara Patterson, MA, Associate Director for Policy, NCIPC
- Thomas R. Simon, PhD, Acting Associate Director for Science, Division of Violence Prevention (DVP), NCIPC
- David A. Sleet, PhD, Associate Director for Science, Division of Unintentional Injury Prevention (DUIP), NCIPC
- Howard Spivak, MD, Director, Division of Violence Prevention (DVP), NCIPC
- James W. Stephens, PhD, NCIPC Deputy Director
- David G. Williamson, PhD, Acting NCIPC Associate Director for Science

Others Present / Affiliation

- Stephanie Henry-Wallace, PhD, Writer / Editor, Cambridge Communications & Training Institute (CCTI)

**Announcements**

David Williamson, PhD
Acting Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Williamson welcomed everyone, noting that he had been in the Center for about six to seven months since Dr. Degutis had invited him to serve as the Acting Associate Director for Science. As a preamble to what he was about to present, he said it had been a wonderful opportunity for him to learn so much about the important work that is done in the center and that the BSC supports. He reported that the NCIPC Extramural Research Program Office (ERPO)

would publish five funding opportunity announcements (FOAs), which would be in the areas of prescription drug overdose, motor vehicles, health planning, interpersonal violence, and sexual violence. This is a nice plethora of topics that hopefully will provide many opportunities for inroads into prevention strategies for injury and violence.

With regard to the activities of the divisions, the Division of Analysis, Research, and Practice Integration (DARPI) welcomed a new permanent Associate Director for Science, Dr. Karin Mack.

There are some exciting and monumental efforts upcoming in the Division of Unintentional Injury Prevention (DUIP). In December 2013, DUIP will release a report on the Medicaid Patient Review and Restriction (PRR) Programs that will summarize lessons learned from states in controlling the prescription drug overdose epidemic. In January 2014, a *Community Guide* Cochrane Review will be released on the effectiveness of motorcycle helmet laws in reducing injuries and deaths. DUIP is scheduled to release a CDC Vital Signs™ report on child passenger safety in February 2014. Later in fiscal year (FY) 2014, DUIP will be releasing a program FOA to boost prevention work on prescription drug overdose. The Division of Violence Prevention (DVP) also has several very exciting efforts underway. In September 2013, a supplement was published in the *Journal of Adolescent Health* (JAH) titled "Interrupting Child Maltreatment Across Generations Through Safe, Stable, and Nurturing Relationships" [J Adolesc Health. 2013 Oct;53(4 Suppl):S1-3. doi: 10.1016/j.jadohealth.2013.06.017]. This special issue provides insight into relational factors that influence the integrational cycle of child maltreatment (CM). DVP has worked with the National Institute of Justice (NIJ) to release a book titled *Changing Course: Preventing Gang Membership*, which can be downloaded at: <http://www.cdc.gov/violenceprevention/youthviolence/preventgangmembership/index.html>.

DVP has also been working with the United States (US) Department of Education, the Health Resources and Services Administration (HRSA), and others to develop a definition of "bullying," which has been in the news prominently lately. The 2010 National Violent Death Reporting System (NVDRS) data will be released in December 2013, which will include data from the 16 states currently included in the system. A CDC Public Health Grand Rounds is scheduled for February 2014 with a focus on youth violence prevention, which will be available online. During the Spring of 2014, there will be a new release of the National Intimate Partner and Sexual Violence Survey (NISVS) data, which includes an extended summary on intimate partner violence (IPV) and a summary report in the *Morbidity and Mortality Weekly Report (MMWR)* on the 2011 data.

Discussion Points

Dr. Fowler requested that Dr. Williamson offer more information about the call for proposals with regard to the health planning focus.

Dr. Williamson replied that he was not at liberty to say too much about the announcements because NCIPC was in the process of providing the FOA to potential applicants, and there were people in the room who would perhaps be reviewing that FOA very closely.

Dr. Haegerich added that the health planning focus was largely about integrating injury prevention within clinical medicine and health systems.

Dr. Sleet noted that the January 2014 release date for the *Community Guide* Cochrane Review was not definite, and that it could be before or after that timeframe.

Approval of Last Meeting Minutes

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 for a motion to approve the meeting minutes from the eleventh BSC meeting on June 13-14, 2013. **Dr. Mickalide** moved to approve the meeting minutes with no revisions. **Dr. Timmons** seconded the motion. The minutes were approved unanimously with no abstentions.

Director's Update

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

Dr. Degutis emphasized that the shutdown had resulted in a backlog of work on which NCIPC was still trying to catch up. Numerous meetings had to be rescheduled, with some now overlapping. While staff members were working diligently to ensure that they do everything possible to support people, it would be unreasonable to expect that they work 24/7. She expressed her appreciation for how much staff members had been able to accomplish thus far, and for the patience of those outside the agency.

She then provided the BSC with updates on major issues and initiatives at NCIPC. As Dr. Williamson noted, Dr. Jimmy Stephens was appointed as the new NCIPC Deputy Director. He joined the center at the end of August 2013, and Dr. Degutis requested that he introduce himself. **Dr. Stephens** said he was really delighted to be there, noting that he was new to NCIPC and was in some ways new to the injury field. He worked for the National Institute for Occupational Safety and Health (NIOSH) for a number of years, where he began working in 1992. During his tenure at NIOSH, he worked in a variety of positions, including as the Associate Director for Science. He spent the last seven years of his career in the Office of the Director (OD) of the Centers for Disease Control and Prevention (CDC) where he was engaged in a number of injury topics. While he was new to injury, he said he was not completely unfamiliar with the issues occurring within NCIPC and the injury field in general. He said he was delighted to be there, and was looking forward to working with everyone in a variety of roles, including the BSC.

Dr. Degutis reported that a new DARPI Division Director, Dr. Rod McClure, had been hired. DARPI just celebrated its first birthday and includes the Core State VIPP and Statistics Team, Programming Team, and Health Economics and Policy Research Team. Dr. McClure will be joining the center after the first of the year. An exact date was not known at the time of this BSC meeting, given that there were a number of internal processes that must be completed over which NCIPC had no control. She expressed appreciation for all of the work Jim Enders had done to ensure that DARPI continued to grow and function in the interim.

Prescription drug overdose is an issue on which NCIPC is focusing center-wide, and it is a major priority for CDC. Dr. Degutis pointed out that this offered an opportunity for some recognition within CDC and externally in terms of the types of work NCIPC could do to have an impact on this major public health problem. Staffing changes were anticipated, and Dr. Baldwin was working to ensure that there were smooth transitions and that a robust team was in place. The entire division was active in trying to ensure this, and NCIPC has been considering efforts to engage staff from various parts of the center in the initiative to “stem the tide” of the epidemic.

Given that President Obama made an announcement in January 2013 that \$10 million in funds should be allocated to NCIPC for research on fire arms, there was a misperception that NCIPC already has those funds. An additional \$20 million was proposed to expand the NVDRS. Dr. Degutis reminded everyone that those were proposals, and that no funds had been received to date. The CDC Foundation funded the Institute of Medicine (IOM) to create a consensus report on a proposed public health research agenda on firearm violence. Titled “Priorities for a Public Health Research Agenda to Reduce the Threat of Firearm-Related Violence,” this report can be found at: <http://www.iom.edu/Activities/PublicHealth/FirearmViolenceReduction.aspx>. Dr. Hargarten was part of that committee, which was comprised of a fairly diverse group of people who wrote the review in record time.

NCIPC contributed to a report on concussions in youth that the IOM published in October 2013 titled “Sports-Related Concussions in Youth: Improving the Science, Changing the Culture.” This report can be found at: <http://www.iom.edu/Reports/2013/Sports-Related-Concussions-in-Youth-Improving-the-Science-Changing-the-Culture.aspx#sthash.HVuMhGBO.dpuf>. This report ties into NCIPC’s efforts in the Heads Up program in terms of preventing sports-related concussions, particularly in youth.

The center continues to work within four focus areas: Prescription Painkiller Drug Overdose, Motor Vehicle-Related Injury Prevention, Prevention of Violence Against Children and Youth, and Prevention of Traumatic Brain Injury (TBI). In addition, Susan Hillis has been working with staff working in global health on a strategic plan for global initiatives. Though this effort was delayed somewhat due to the shutdown, it should be completed at the beginning of 2014. Significant work is being done in violence against children through violence against children surveys that have been ongoing for the past several years. That initiative is being led by Jim Mercy and is being done with funding from the President’s Emergency Plan For AIDS Relief (PEPFAR). Currently, NCIPC is trying to find additional ways to fund these surveys in non-PEPFAR countries because there has been a lot of interest from other places in conducting these surveys. The surveys involve engagement of the Ministries of Health and other partners in country, so NCIPC’s piece is first to assess what is occurring and whether there truly is a commitment from the country government to participate and do something with it. Some reports and data have been published. A recent analysis of the data was done for Haiti, and data were recently released for Zimbabwe. The countries are using these data to design interventions to decrease violence against children. One of the newer aspects of this effort is assessing this issue in homeless youth.

Another major global health initiative pertains to reducing traffic-related injuries. NCIPC is working collaboratively with NIOSH on a project in India, which is due to be finalized in March 2014. CDC's National Center for Environmental Health (NCEH) is engaged in some work on cook stoves, so NCIPC has been collaborating with them on that initiative and is conducting some work on burns and burn registries in India. Other potential global opportunities are also being considered.

NCIPC has also been assessing how to describe and document the center's impact, and recently completed two half-day workshops on writing impact statements. For this workshop, the focus was on the prescription drug overdose imitative and firearm violence with regard to how to document how to use the science available to create an impact on public health and how to message that to various communities, stakeholders, and the general public. This is an issue throughout CDC. Dr. Frieden is seeking to document efforts that have a shorter term impact on public health, so NCIPC is attempting to be proactive in the endeavor to document its impact in the field. This is more challenging in injury and violence than perhaps in immunization, for which the number of immunizations administered and the number of people who present with influenza can be measured.

Also exciting is that Web-based Injury Statistics Query and Reporting System (WISQARS) iPad app is probably going to be released publically shorter after the first of the year. At the time of this meeting, the app was in a beta test phase. This app will be available free through the iTunes store.

Discussion Points

Dr. Hargarten inquired as to who is leading the global initiatives.

Dr. Degutis responded that Dr. Hillis is leading the strategic plan effort and that Dr. Jim Mercy is leading the violence against children survey effort. Dr. Hillis is the overall global health generalist.

Dr. Baldwin added that DUIP's focus has been on global road safety and burns. The burn activities are being led by Dr. Sugerman, while the global road safety activities are being led by Drs. Sleet and Erin Parker.

Dr. Hillis added that she is also leading the global suicide prevention work.

Dr. Hamby inquired about the status and direction of the firearms effort, and whether NCIPC anticipated that additional funding would be forthcoming for that initiative or if the center would be planning other initiatives with its current budget.

Dr. Degutis responded that NCIPC had no idea what would occur with the funding. It is up to Congress to decide what is included in the budget, and what is included as a budget line should additional funding be allocated to the center. Given the current budget climate, NCIPC is not optimistic and is still operating under the Continuing Resolution (CR) until January 15, 2014. It is not clear whether at that time there will be a budget or another CR. NCIPC's current funding is at the 2013 level, with no expectation that there will be an increase. Unless something changes, there will be another sequester in January 2014 with another across the board cut. In terms of the firearms funding itself, NCIPC continues to conduct the surveillance work it has been doing since the inception of the center. However, there are no center activities focused solely on firearms. Most of NCIPC's funds are already committed to other efforts.

Dr. Hamby noted that the National Institutes of Health (NIH) published a call for firearm research, and she inquired as to whether they received funding and NCIPC did not, or if NIH was using existing funds.

Dr. Degutis replied that NIH is using existing funds, and they published a general call for violence research with a highlight on firearms as one of the priorities of the call. It was not a specific call for firearm research.

Dr. Hargarten commended Dr. Degutis for her leadership in getting the IOM report written and disseminated. He said he was aware of at least two Request for Funding Announcements (RFAs) from private foundation venture fund groups that are specific to firearm-related research. The IOM report served as a catalyst for funding streams. Unfortunately, it has not served as a catalyst for funding streams specifically for NCIPC.

Dr. Degutis agreed that the IOM report had helped to identify some of the gaps that need to be filled.

Dr. Hamby concurred and reported that she had heard numerous references to the IOM report in the last few months. She said she thought it was quite impressive that the report was completed in such a short period of time when it was still timely and on people's minds.

Dr. Degutis noted that another incident that might highlight the issue again was the upcoming anniversary of the Sandy Hook shooting.

Dr. Fowler asked what observations were being made about work being passed down to NCIPC related to the Affordable Care Act (ACA).

Dr. Degutis responded that one benefit of the ACA is the focus on prevention and the ability to receive reimbursement for preventive services. NCIPC has not been assigned any specific tasks with respect to the ACA, but does see opportunities with regard to the linkage between clinical medicine and public health, which is one of Dr. Frieden's priorities. Consideration is being given to how NCIPC can enhance that linkage and do more with respect to prevention by using that linkage. NCIPC is being proactive in some of its work and in its relationships with other agencies. As part of the prescription drug overdose initiative, Dr. Chris Jones, Health Scientist of the NCIPC staff is spending 25% of his time with Centers for Medicare and Medicaid Services (CMS) working to create linkages between NCIPC and CMS's initiative in Medicare and Medicaid to help decrease improper use of prescription opioids. That is an example that ties into the ACA at some level. NCIPC also looks to grantees to be innovative as well.

Dr. Mickalide inquired as to whether there would be a discussion or presentation about all of the projects that stemmed from the "National Action Plan for Child Injury Prevention." Nine were funded.

Dr. Baldwin replied that they were nearing the end stage of that implementation process, and he would be open to holding a webinar or posting on NCIPC's internet site the major findings of the "National Action Plan for Child Injury Prevention" implementation work. The division is in the process of revisiting next steps. As Dr. Degutis indicated earlier, regarding issues pertaining to sequestration and budget pressure, they are struggling to find space in the budget to allow for additional expenses in child injury. They have been buoyed by recent activities like the

formation of the Child Safety Caucus and others showcasing the general interest and conversation in raising the visibility of child injury prevention as an issue.

Dr. Mickalide said she thought it was clever and excellent that the division funded nine organizations to extend the work of that two-year process, and was hopeful that more organizations in the future would be able to use the “National Action Plan for Child Injury Prevention” as a roadmap for their own work. It makes the wonderful leap between the practice and research communities, and ties the work together in a way that has been needed in the field for a very long time, so she wanted to commend CDC for taking that strategy with the “National Action Plan for Child Injury Prevention.”

Dr. Baldwin thanked Dr. Mickalide, noting that a lot of thought and work went into figuring out how to best do that. The concern of those who were central to the “National Action Plan for Child Injury Prevention” implementation regarded how to carry forward the momentum and tremendous energy.

Dr. Mickalide suggested that placing key findings on the website and perhaps having a panel at an upcoming national meeting might be a way to extend the reach.

Dr. Nation noted that the American Psychological Association (APA) sent out a notice that they were doing some violence prevention bullying intervention through the Division of Adolescent School Health (DASH). NCIPC mentioned some of its work pertaining to bullying as well, and he wondered whether that was connected or if NCIPC was collaborating with DASH on that.

Dr. Spivak responded that NCIPC is working with DASH. This is not just within CDC. There is a collaborative across several federal agencies on this as well in terms of sharing information, creating access to information, and integrating some of the bullying work into other activities.

Dr. Fowler requested that Dr. Degutis further discuss the statement of impact. She was thinking when Dr. Hargarten was congratulating Dr. Degutis on her leadership and the IOM report, that it is wonderful that funding is appearing in other places for this work. She wondered how well they were able to get out the message that NCIPC is leading this issue, so that hopefully funding is allocated to the center in the future. She also requested that Dr. Degutis speak about the training she required everyone to take.

Dr. Degutis replied that one way NCIPC highlights some of its involvement is through data, surveillance, and the work that NCIPC continues to do. It is a challenge for NCIPC to be seen as taking leadership without having some specific funding or ways of moving this forward. One way that NCIPC has framed things is that CDC is the leading public health agency for the nation in talking about violence overall, and this is really one piece of it. Obviously, the other issues (e.g., bullying, child maltreatment, intimate partner violence, sexual violence, suicide) are a piece of this. For a number of reasons, it is currently extremely difficult to go out to say this is the lead public health agency dealing with gun violence. Fostering the IOM initiative raised a lot of awareness. It will take time for the overall impact, but it will allow people to assess what really needs to be done and where the gaps are. NCIPC does see itself as being able to provide leadership to the other federal agencies with respect to identifying each agency's priorities, how agencies can collaborate, and how agencies' activities can be leveraged to create a more collaborative federal initiative in this area. They do not want people to think that NCIPC is engaged in work that is duplicative. Efforts need to be viewed as collaborative or as certain agencies having unique niches. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has a unique niche with respect to mental health. NCIPC

has surveillance data systems. The Department of Justice (DOJ) has its own areas with regard to enforcement and criminal justice issues, and keeping youth out of the criminal justice system. NCIPC has been working with the National Forum on Youth Violence, which ties back to the firearms and other types of youth violence. These are opportunities for NCIPC to take a leadership role.

Dr. Hamby indicated that she serves on the APA Media Violence Task Force, which is reviewing and updating their policy positions on the impact of violent video games. She wondered whether CDC has any resources or official policy statements, or if the agency gets involved in violent video games or other violent media issues at all.

Dr. Simon replied that they do not have an official position, but gaps in the field have been identified and are reflected in the research agenda. Several studies have been funded in the past to specifically assess the extent to which there is a linkage between exposure to media violence in various forms, in particular new forms of media (e.g., internet, video games) in relation to aggressive behavior. Limited information is known about the relationship with more forms of aggressive behavior, and it is known that most children who are exposed to violent media content do not act aggressively. The gap has also been emphasized in terms of the understanding of what makes a vulnerable population, and who is most susceptible to the influence of violent media content.

Health Communication Portfolio Review

Background and Overview

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

For full disclosure, **Dr. Greenspan** pointed out that many of the slides in her presentation were presented previously during an external panel meeting, and were assembled by the contractor, FHI 360. She explained that this was a major and center-wide effort. There was an internal NCIPC Workgroup that included communication scientists from each of the divisions and the OD, evaluation scientists who guided the efforts to ensure that they remained true to the evaluation methods, and fellows who assisted in the effort. The NCIPC Workgroup consisted of the following individuals:

- Teri Barber, MA, Health Communication Specialist
- Mary Bovenzi, MPH, Public Health Prevention Service Fellow
- Erin Connelly, MPA ff, Acting Associate Director for Communication
- Paige Cucchi, MSPH, Health Communication Specialist
- Robert J.M. Greathouse, MPH, Public Health Prevention Service Fellow
- Michele Huitric, MPH, Health Communication Lead
- Margaret Kaniewski, MPH, Public Health Advisor
- Kelly Sarmiento, MPH, Health Communication Specialist
- Sally Thigpen, MPA , Health Scientist
- Charniece Tisdale, MPH, CHES, Public Health Prevention Service Fellow
- Sue Lin Yee, MA, MPH, Senior Evaluation Scientist

The Portfolio Review External Peer Review Panel was comprised of the following members:

- Carolyn J. Cumpsty Fowler, PhD, MPH (Chair), Johns Hopkins University
- Jay Bernhardt, PhD, MPH, University of Florida
- Susan Kirby, DrPH, MPH, Kirby Marketing Solutions
- Matthew Kreuter, PhD, MPH, Washington University
- David Nelson, MD, MPH, National Cancer Institute
- Flora Winston, MD. PhD, Children's Hospital of Philadelphia

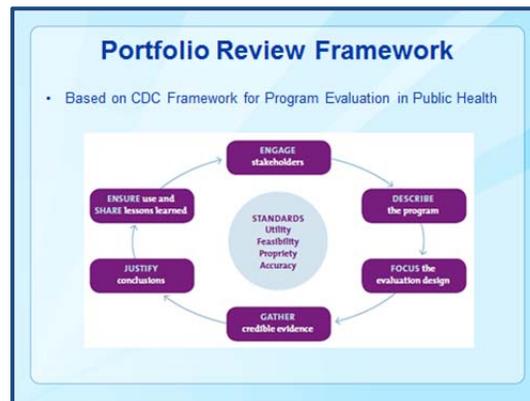
Dr. Greenspan emphasized that Dr. Fowler did a great job in giving life to the results, providing recommendations, and helping NCIPC pull things together. Also involved in the project were the contractors, FHI 360 and SciMetrika, who did some of the "heavy lifting" in terms of compiling information and conducting interviews for NCIPC.

There were some challenges with this review. It was the first cross-cutting review. In the past, all of NCIPC's portfolio reviews have been topic-specific. Not only was this the first time this was done in the center, but also it may have been the first time this has been done within CDC as an agency. Internal reviews are mandated to evaluate the agency's internal science and internal programs. It is typical within NCIPC and throughout the agency to conduct these reviews on specific topic areas. NCIPC sought to look more broadly for this review. Because of the impact that communication can have, especially to communicate the science, NCIPC thought that it would be a good task to review NCIPC's communication programs in terms of how they operate and how they assist in moving science forward. There were some challenges in doing this through three divisions and the OD. In the midst of this review, there was a reorganization that really impacted on the original structure, given that some people moved from one division to another. There was some disruption due to that. There was also a change in contractors, which was also disruptive. In addition, there were some staff changes on the evaluation team of individuals who were instrumental in helping guide these evaluation projects. Sue Lin Yee, who has been guiding these portfolio evaluations for the past several reviews, took a new position and this effort was handed off to someone else. The staff changes also presented challenges in getting people "up to speed" on this review. Nevertheless, they forged ahead and completed the review.

For the purpose of the review, "health communication" was defined as the "study and use of communication strategies to inform and influence individual and community decisions that affect health." The primary goal of the portfolio review was to produce actionable recommendations for future decision making and allocation of resources. The portfolio review also provided an opportunity to:

- Promote understanding of the capabilities and functions of health communication expertise within the Injury Center
- Obtain an in-depth knowledge of the range of health communication research and activities occurring within the Injury Center
- Capture and understand use of health communication best practices within the Injury Center
- Identify key health communication activities and explore resources and strategies for establishing alignment of essential health communication within the Injury Center
- Recommend strategies for ensuring that health communication work is instrumental in improving the Injury Center's goals and metrics

The portfolio review framework was based on CDC's Framework for Program Evaluation in Public Health, which is depicted in the following diagram:



The evaluation questions and the approaches to address them were as follows:

Evaluation Question 1

- To what extent have the selected Injury Center health communication activities been effective in achieving the projects' own communication objectives?
- Approach to address:
 - Descriptive analysis of submitted project materials
 - Follow-up interviews with Injury Center staff

Evaluation Question 2

- What health communication science best practices exist in the field, and to what extent are the best practices incorporated or reflected in the selected Injury Center health communication activities?
- Approach to address:
 - Targeted review of literature to identify best practices
 - Comparison of existing practices for Injury Center as identified in the analysis of submitted materials for each project selected for the portfolio
 - Follow-up interviews with Injury Center staff

Evaluation Question 3

- Across the selected Injury Center health communication activities, what facilitators made achievement of communications objectives more easily attainable? Conversely, what barriers hindered the achievement of communication objectives?
- Approach to address:
 - Interviews with CDC health communication experts and external experts
 - Interviews with workgroup members
 - Review of potential facilitators and barriers for each project

There was a significant amount of discussion regarding the selection of health communication activities. While ideally it would have been nice to have assessed all of the activities during the time period from 2006 through 2011, this was not possible within the timeframe and available resources. Thus, the decision was made to ensure that each communication activity identified captured the seven main health communication efforts of the center, which include: 1) campaigns and initiatives; 2) capacity-building for communication science; 3) media and channel management; 4) data and publication releases; 5) organizational communication, identity, and branding; 6) product launches; and 7) research and analysis. The panel wanted to ensure that activities selected for each of the seven areas were representative of each of the divisions and communications staff in the Office of the Director. The activities selected for each area for the review follow:

Campaigns and Initiatives

- ❑ *Heads Up: Concussion in High School Sports*. This was the first nationwide concussion awareness-building effort focused on high school youths. This effort aims to protect teens from concussions by providing materials to key audiences including coaches, parents, and student athletes.
- ❑ *Parents Are the Key: Pilot Campaign and National Launch*. This campaign was developed to increase parental awareness of the importance of actively managing teen driving. It offers parents of new teen drivers (15–18 years old) tools, proven steps, and a campaign tool kit for reducing teen driving injuries and deaths.

Capacity-Building for Communication Science

- ❑ *Adding Power to Our Voices Framing Project*. This project focused on building the capacity of violence and injury partners and grantees to use a consistent injury frame, and message framing techniques in their communications.

Media and Channel Management

- ❑ *Bullying Twitter LiveChat*. The Injury Center uses real-time Twitter chats to engage and interact with fans and followers to foster discussion and encourage efforts to affect change. A LiveChat about bullying included over 200 participating partners who sent out over 600 tweets.

Data and Publication Releases

- ❑ *Launch of the NISVS 2010 Summary Report*. This report aimed to increase awareness of intimate partner violence/sexual violence prevalence, relevance, and preventability; promote resources of the National Intimate Partner and Sexual Violence Survey; and translate existing data to action items for key audiences. Activities included producing a communication toolkit, webinar, listserv announcements, media outreach, and social media.
- ❑ *Vital Signs™: Prescription Painkiller Overdoses in the US*. *Vital Signs™* is a CDC program offering recent data and calls to action for important public health issues. Each *Vital Signs™* package consists of several parts, including an *MMWR* article; a fact sheet for consumer audiences, as well as a dedicated website; media outreach (media teleconference and press release); and a series of announcements via social media tools (Twitter, Facebook, et cetera).

Organizational Communication, Identity, and Branding

- ❑ CDC Injury Center Brand Identity Project. To aid staff in communicating the value of the Injury Center's work to key constituents, a brand identity platform and messaging framework were developed. This effort included a Brand Identity Guide, Branding Wiki (provided tools and recommendations), and a Center-wide Branding Workgroup.

Product Launches

- ❑ Web-based Injury Statistics Query and Reporting System (WISQARS) Cost of Injury Module Launch. This module allows users to produce estimates of costs associated with injury-related deaths, hospitalizations, and emergency department visits. The module launch made use of existing communication channels for promotion including the web, email, print publications, webinars, conferences and meetings.
- ❑ Principles of Prevention Integrated Web-based Training. This is theory-driven online training to increase practitioners' understanding of key concepts of effective violence prevention through primary prevention, public health approaches, and the social-ecological model. Free continuing education is offered for physicians, nurses, and other health professionals. Promotion included distribution of an informational flyer via conferences and email and a promotional web badge.
- ❑ *Field Triage Decision Scheme: The National Trauma Triage Protocol*. This protocol is intended to guide on-scene triage decisions of emergency medical services (EMS) providers. A variety of educational materials were created to distribute the guidelines and train EMS professionals, including a smart phone application, posters, badge, and online training with CEU credits. The guidelines were promoted using a targeted media strategy, for example through trade magazines, conferences, and a media advisory.

Research and Analysis

- ❑ Several of the health communication activities included research and analysis efforts to inform specific communication efforts and/or to contribute more broadly to communication science:
 - *Parents Are the Key*: Pilot Campaign and National Launch
 - Launch of the *NISVS 2010 Summary Report*
 - *Heads Up: Concussion in High School Sports*
 - *Field Triage Decision Scheme: The National Trauma Triage Protocol*

Dr. Greenspan indicated that for more information, she could be contacted at AIG0@cdc.gov. She then invited Dr. Fowler, Chair of the Portfolio Review External Peer Review Panel, to present the Health Communication Portfolio Review results, conclusions, and recommendations.

Results, Conclusions, and Recommendations

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 referred everyone to the document they were provided prior to the meeting dated August 26, 2013 and titled, *CDC's National Center for Injury Prevention and Control: Health Communication Portfolio Review*, and requested that they open it. For the record, she indicated that this was the second portfolio review she has chaired for NCIPC, and that this was an absolutely wonderful experience. She said she was in awe of everyone on the Portfolio Review External Peer Review Panel she was chairing, and that the contractor, FHI 360 were stunning to work with. They were very professional, and also were with the panel during the external review day. Their careful attention to detail in terms of documenting what was being said and in helping the panelists organize their thoughts as they went through the day produced a much more effective report than it would have been had they not been present. Thus, she thanked FHI 360 very much for their help.

Pointing out that the basic results could be found on page 34 of the document, Dr. Fowler began by discussing what the panel was asked to do, how they did it, and their findings. The three charges were to:

1. Identify strengths of the Injury Center's health communication activities and actionable recommendations for expanding these strengths.
2. Identify areas for improvement and gaps in the Injury Center's health communication activities and actionable strategies for addressing improvement areas and gaps, as well as strategies to overcome existing barriers.
3. Identify ways to improve communication activities with and without additional resources and identify ways to leverage resources and partnerships.

Panel members all received the draft report, and Dr. Fowler requested that each of the members review the report and told them that they would be conducting a Strengths, Weakness, Opportunities, and Threats (SWOT) analysis to form the framework of their discussions. When they began talking together during the review day, they went through a slightly different process of assessing the strengths and opportunities being leveraged, then the weaknesses, and then the threats. As Dr. Greenspan reported, the evaluation itself was only conducted on a sample of 10 activities. Therefore, many of the findings are relevant only to those 10 activities. At the outset, the panel identified this as a substantial limitation to this portfolio review process. Panelists understood the need for it practically, but it was very much a limitation. With Dr. Degutis's permission and where possible, the panel included additional insight and recommendations to NCIPC based on the panel members' past experience with Injury Center communication work, and their expertise in the field of health communication. Thus, they had experience with some of the communication activities that had not been included. Based on this, the panel also made some significant recommendations about how portfolio reviews should be done in the future. Those do not belong in the official report of the panel's findings of the review itself, but are included in Appendix D on page 94.

With regard to the strengths and opportunities, the panel was impressed that NCIPC was the first center within CDC to conduct a cross-cutting portfolio review. The panel recognized that NCIPC has established a solid foundation for this work, given that about 10% of the center's full-time staff and about 5% of the center's budget are dedicated to this effort. The panel felt that another strength was the agency itself and the center's reputation, and the very systematic use NCIPC makes of channels such as Vital Signs™. NCIPC is very good at capitalizing on the CDC brand. The panel felt that the center does a good job raising issues of high public health importance. Though not in the review report, the panel also liked that the fact that many of the Injury Center's messages are very solution- and win-focused, such as the "Winnable Battles" being used by Dr. Frieden. The panel also felt that NCIPC has leveraged some of the high-interest topics, and has to some extent been leveraging seasonal communication.

There was evidence of an attempt to ground health communication activities in best practices. All of the projects included stated goals, purpose statements, and audiences identified. However, the panel found the goals and statements in most cases to be vague and rudimentary. Also commendable is that at least some evaluation activities were conducted on each of the 10 health communication projects in the portfolio, and that mixed methods were used for evaluation in many cases. The panel applauded NCIPC for its diverse and impressive range of activities; willingness to use new methods; willingness to use public-private partnerships; and the recent move of health communication staff into the divisions, which integrated science and communication expertise.

Pertaining to the weaknesses and gaps, the panel was concerned about the lack of a clear purpose for the health communication activities within NCIPC. In looking at the evaluations, it seemed to the panelists that many of the programs were essentially more public relations focused as opposed to health promotion focused. The panel acknowledged that public relations is important, but did not want it to detract from the work of evidence-based health promotion for public health. Panelists also felt that some of the messages were confined to a very narrow spectrum, with most of the stated outcomes focused on raising awareness or disseminating resources and information. The panel felt that NCIPC should be broadening the desired outcomes, moving toward changing behaviors and informing policy. It was unclear in the portfolio review whether the health communication efforts served as an independent activity or were integrated as part of a larger project.

Missing in the evaluation was a breakdown of the roles, training, expertise, and responsibilities of the people doing the health communication work. However, NCIPC was quick to clarify this for the panel. At least three of the panel members were quite outspoken about the fact that NCIPC has to have high level, influential, and current expertise in order to engage in health communication work. The panel was not sure whether when messages are distributed to partner stakeholders, that those partners really have the capacity to spread the messages. The issue of planning, evaluation, and strategy for health communication was hands down the main topic of conversation during the review. There is a major opportunity for improvement in planning. The panel members kept commenting that they needed to see a lot more of the *why* of the campaigns being documented. Panelists also noticed that without exception no specific, measurable, achievable, relevant, time-specific (SMART) objectives were stated. The generic nature of the objectives compromises the ability to evaluate success.

The panel also felt that there could be better audience segmentation, as well as a better description of the audiences for whom these materials were intended. Evaluation for the portfolio projects was largely limited to process evaluation, which the panel felt could have been somewhat more robust. The lack of baseline data made it difficult to gauge real impact of health

communication efforts. Some really good work is being done, and several panelists felt that there was a lack of data that would help NCIPC demonstrate their return on investment for the work the center is doing in health communications. Another issue the panel raised regarded whether the engagement with partners and stakeholders in these various activities was, in fact, strategic. The panel felt that there was an opportunity for the Injury Center to be strategic in its partnerships, and also to have a role in enabling those partners and stakeholders in disseminating NCIPC's messages. Another challenge, which the panel knew at the outset, was that the portfolio review did not really address evidence-based implementation because as correctly stated, there are different types of evidence for different types of communication strategies. However, the panel felt that this omission was a key deficit and that at the very least, there should be some generic best practice steps included

The panel also spent a lot of time discussing missed opportunities and considered how, given the clearance requirements and challenges, or despite those, NCIPC could respond more effectively and quickly. Panelists thought that perhaps proactively creating some messages to respond to the common and high-profile issues might allow NCIPC to respond more effectively and in a timely manner. The panel also felt that there were still unleveraged partner and stakeholder opportunities for dissemination. Similarly, panel members felt that some of the network/social media monitoring and analytics had been under-utilized. The panel also encouraged NCIPC to incorporate or start thinking about including messages into some of the private sector corporate and self-insured wellness programs.

Panelists thought that some of the potential threats had to do with the situation within which NCIPC has to function versus NCIPC itself. There are some constraints with which the Injury Center has to deal, but the panel also felt that there would be issues of competition for space or air time and encouraged NCIPC to share resources and repurpose activities to avoid duplication. Finally, the panel encouraged NCIPC to not ignore the real costs associated with so-called "free" communication channels, because somebody has to manage and monitor them and follow up.

The panel provided six recommendations in priority order that begin on page 70 of the report, and intentionally included short-term and long-term recommendations:

1. Set clear purposes for health communication at the Center, division, and project levels with an emphasis on public health over public relations. Decide the role of health communication in the Injury Center and in the field of injury prevention more broadly.

Short-Term:

- Determine when the Injury Center should lead health communication efforts vs. when to support or initiate efforts that could subsequently be carried forward by others, including stakeholders or partners.
- Clearly articulate the purpose and objectives for every health communication project and ensure awareness among all key Center decision makers.

2. Set clear priorities for health communication at the Center, division, and project level. Consider agency or department priorities. Be realistic about what can be done effectively with existing Center strengths and current staffing, funding, or time available. It is better to do fewer activities and excel at them, than to spread resources thinly across many efforts.

Short-Term:

- Quantify staff time and fiscal resources required to meet mandated activities at the agency, department, Center, division, and branch levels, and determine what can be accomplished with remaining resources.
- Plan ahead to devote a portion of staff time to reactive communications (e.g., crisis response, media inquiries) so that these activities do not distract from or derail proactive, strategic health communication efforts.
- Assess the balance between health promotion efforts and PR activities. Adjust this ratio as necessary to align with Injury Center priorities.

3. Enhance rigor of planning and evaluation. In keeping with the CDC's emphasis on science, follow best practices for health communication planning and evaluation. Demonstrating the effectiveness and value of health communication activities requires being able to show evidence-based results.

Short-Term:

- Develop a planning and evaluation clearance process. For example, require that any project above a certain threshold for time and/or resource utilization be reviewed for planning and evaluation best practices before implementation can begin. Encourage projects below this threshold to voluntarily complete such a review.
- Develop SMART objectives and logic models as appropriate for the scale of activities, and consider evaluation at the outset of a project.
- Conduct in-service training in evaluation best practices for the Injury Center communication workforce.

Long-Term:

- Hire a communication evaluation specialist or contractor to provide communication evaluation expertise across the Center.
- Set aside specific funding for evaluation on each project, and establish a centralized evaluation funding source for communication activities that do not have an operational budget beyond personnel.
- Use current and expanded metrics to show outcomes and return on investment, which can demonstrate the value of health communication to injury prevention.

4. Assess health communication expertise and capacity. Align workforce and resources with Center communication goals and priorities.

Short-Term:

- Evaluate the strengths of existing staff based on priority functions, responsibilities, and communication channels, and identify any gaps that may hinder accomplishment of Center communication goals.

Long-Term:

- Ensure that senior health communicators are highly trained in health communication science and have a proven track record of effective communication. Consider hiring more than one behavioral scientist to contribute to the Center's health communication work.
- Explore ways to fill gaps in staff capacity or expertise, including the use of external resources.

5. Maximize internal and external resources, recognizing that some activities can be accomplished most effectively and/or efficiently by external entities.

Short-Term:

- Engage stakeholders and extramural grantees in communication planning and evaluation. For instance, leverage stakeholder resources such as through asking them to provide audience research or to disseminate messages or products.
- Maximize use of existing CDC brand and communication channels (such as Vital Signs™, *MMWR*).
- Use end-of-year funds strategically. Identify “evergreen” projects and/or communication infrastructure needs that can be planned and approved quickly if funds become available.

Long-Term:

- Leverage CDC's reputation as a producer of data and evidence-based prevention messages, and incorporate scientific evidence in health promotion messages.
- Explore jointly funded communication projects, such as with other federal agencies as well as nongovernmental organizations.

6. Plan and design for adaptability and sustainability. Plan explicitly for human and fiscal resources needed to maintain campaigns and resources that prove successful. Regularly reevaluate overall health communication strategy to ensure alignment with changing priorities.

Short-Term:

- Expand expertise in social media and viral messaging. Designate one staff person, or a core of staff members, to develop in-depth understanding of these media and commit to remaining current in it.

Long-Term:

- Develop staff expertise in translation and dissemination to take effective programs to scale, or engage outside vendors to do so.
- Require and/or reward continuing education of staff to develop and maintain a cutting-edge health communication workforce that can adapt to rapidly changing communication technologies and strategies. Integrate such training into staff professional development plans.
- Establish online infrastructure to be used across projects, such as systems to extend and customize materials for diverse purposes or audiences (e.g., MIYO [Make it Your Own]), to expand reach and utility.

Dr. Fowler thanked her fellow panel members for being very thoughtful about how to develop recommendations that were actionable, given the constraints with which their colleagues at NCIPC have to deal. She also expressed gratitude to the NCIPC staff for being highly responsive to these suggestions during the debriefing. In addition, she commended FHI 360 for the difference in the writing style and look of the report.

Discussion Points

Dr. Hamby said she found the report to be very interesting and she thought it was terrific for CDC to invest in communication, because that is a key gap in so much of what is done and one of the reasons the science-to-practice and practice-to-science links do not occur as smoothly as is needed in violence and injury prevention issues. She suggested considering taking some experimental approaches to investigating these communication strategies. It is becoming an increasingly common approach in a lot of the informatics world, especially in medicine. NCIPC has tried many strategies, which is definitely a strength and opportunity, but for the most part, they seem very much confounded with the particular topic area. While there is a sense from the evaluation of a very impressive understanding of all of the different communications strategies NCIPC is trying, but there is not a sense of whether it is better to utilize a TwitterChat or a Facebook page. If more comparisons were built directly into each particular project, NCIPC would be able to get a better sense of where it is getting the “most bang for the buck.” By capturing the number of Tweets, hits, or whatever the metric, it is somewhat difficult to tell whether those are because people are more interested in bullying than they are in sports concussions or perhaps the other way around. Therefore, she encouraged NCIPC to conduct more head-to-head comparisons of the different communication strategies within each project to try to evaluate which ones seem to be most effective.

Dr. Fowler said that was actually discussed, and may be what was intended in having people who have real expertise in social media be part of this. She thought the suggestion would be a very valuable addition.

Dr. Hamby said she would support that recommendation as well, but noted that there was already a tremendous amount of expertise in terms of people who have experience with experimental design, so they probably could make use of existing expertise for at least some of that.

Dr. Gorman-Smith said when she read the recommendation, she could see that part of what the panel was discussing was that more rigorous evaluation, but it was not explicit in the document. She thought emphasizing that would be important. There are a growing number of good examples of how to do that.

Dr. Fowler emphasized that while nothing could be changed in terms of the evaluation itself, but if anyone felt that the report could be strengthened with some edits to highlight some issues, that could be done. She thought they would then have to convene a call to approve any changes that were made.

Dr. Greenspan responded that secondary approval could be done via a teleconference or email, which was done for a previous portfolio reviews.

With that in mind, **Dr. Fowler** encouraged everyone to raise any issues they had because there was still time to emphasize some of the issues.

As an Experimental Psychologist, **Dr. Testa** agreed with what was said. However, she wondered whether CDC had the resources to do that and perhaps instead they should be relying on published research and focusing already limited time on the actual communication efforts.

Dr. Gorman-Smith said she thought there were examples of low-cost ways to get some of these data, and they should be thinking somewhat creatively about how they might randomize or do some of these head-to-head experiments. She did not think it had to be terribly costly, though she was not saying it was without cost. The benefit would be great in terms of building the science of how this is done, and giving direction to the next generation of this kind of work.

Dr. Fowler requested that when people were not talking to mute their phones, because when not muted there was a lot of interference on the line.

Dr. Testa added that with all of the communication, it was really a “moving target,” because social media is moving and changing so fast. Some of the projects that were reviewed were as early as 2006, and things have changed so it becomes difficult to make comparisons going forward.

Dr. Fowler noted that one of the challenges during the review was that there really was not a lot of clear documentation of the discussion preceding the work, so it was hard to judge whether this was an appropriate decision. The panel felt that moving forward, there had to be much more careful thought about the purpose and appropriate strategy now, and whether the objectives could be accomplished using these methods, given how rapidly these are emerging. Appendix D on page 94 includes this information.

Dr. Nation agreed that this report did read very different from the previous portfolio review, and was much appreciated. There was discussion regarding the difference between public relations and public health, and he wondered whether the panelists discussed making a stronger recommendation about the relative emphasis of CDC on those two goals.

Dr. Fowler was looking at Recommendation 1 herself, and thought the discussion the panel had was to have the emphasis more on achieving public health impact as opposed to public relations in terms of the image or awareness of NCIPC. She thought that recommendation could be strengthened.

Dr. Degutis agreed that this would definitely be helpful.

Dr. Fowler inquired as to whether Dr. Nation had any suggestions for how to word that.

Dr. Nation said he would be happy to draft something to submit to her subsequent to the meeting after he had time to think about it.

Dr. Fowler thought they may actually be able to lift a sentence from the report itself in terms of the clarification of what work is intended to achieve public health impact versus promote center.

Dr. Mickalide inquired as to whether they had any sense at all as to the percentage of professionals who go onto the website for CDC and NCIPC compared to the general public.

Dr. Dorigo responded that they do have these metrics. They are also trying to do a better job of breaking that down. They have some high level metrics, but drilling down to different pages, the make-up changes. They are trying to learn more about this right now, but they do have the ability and do have some of this information.

Dr. Fowler referred everyone to page 94 so that they could look over the recommendations for future portfolio reviews. One thing the panel pointed out that was not in the appendix was to draw attention to the fact that for the last two portfolio reviews, the evaluation used a dichotomous yes/no or done/not done measurement. The panel felt that that was completely inadequate to evaluate activities, so they recommended moving to a Likert type of response such as partially implemented/fully implemented or partially done/fully done. The other suggestion, which was a repeat from the last portfolio review, was that the BSC be engaged while the portfolio review is being designed so that the members could have some input into how the questions are being asked or what the methodology is. The BSC is coming in after the fact and saying, "Oh, it's a pity that wasn't considered when it was designed, but it's too late for us to be helpful." Perhaps moving forward, the BSC could be consulted in the design process.

Dr. Greenspan firmly agreed, and suggested that perhaps they discuss this further offline. One of the challenges with this is that NCIPC is sometimes under tight timelines, and needs rapid response to move forward. She really would like to engage the BSC more in the beginning of the process, but they have to figure out the best way of doing that.

Dr. Hamby suggested including additional language in Recommendation 3 about conducting some sort of experimental evaluation or systematic evaluation of different types of communication methods to determine which are most effective across projects.

Dr. Mickalide added that segmenting by audience would also be important, given that what might be successful or beneficial to the general public may be too rudimentary or elementary for those who work in the field. **Dr. Hamby** agreed with that suggestion.

Dr. Fowler requested that those who raised issues email her with the wording within a week or so, so that she could attempt to make revisions to those recommendations accordingly (Dr. Nation Recommendation 1; Drs. Mickalide, Timmons, and Dr. Gorman-Smith Recommendation 3). They agreed to do so. Dr. Fowler pointed out that she could not call for a motion to approve the report yet due to the needed additions, but she inquired as to whether everyone was comfortable moving forward with the additions discussed. Everyone agreed. She indicated that she would make the revisions, and pose them for email confirmation.

Dr. Greenspan confirmed that this would be suitable.

**Topic for the Next Portfolio Review****David Williamson, PhD
Acting Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention**

Dr. Williamson indicated that there had been a lot of discussion about potential topics for the next portfolio review. It seemed to be extremely appropriate and timely to be discussing the next topic being data systems. When thinking about what NCIPC does and its main goal, which is to provide guidance in preventing injury and violence, consideration must be given to how to determine priorities. Hopefully, much of that is data-driven. That means not only the appropriate collection of data, but also the appropriate analysis, appropriate interpretation of the data and results of the analyses, and dissemination of the data. All of that begins with the data themselves—the data systems NCIPC has and the other data regardless of whether it is in systems. It seemed appropriate time-wise because there is a new DARPI Division Director coming on board, and a new Director of Office of Public Health Science and Standards at CDC. That group is in charge of taking a broad look at organizing and coordinating surveillance activities for CDC. It seems important to ensure that there are good public health surveillance systems, good registries, and good collection mechanisms to lead them in the appropriate determination of priorities and hopefully making an impact in NCIPC's work.

Some questions Dr. Williamson thinks are most important for everyone to consider when thinking about the next portfolio review topic are:

- Do our current injury data systems and data to which we have access meet the needs of the Injury Center and the broad injury community?
- What are the data gaps that we address in order to meet and better describe the epidemiology of injury?
- Not only does this pertain to data systems, but also it concerns data in general. How do we get the data out that we utilize? How do we get it into public use datasets? How do we enhance the use of our data and the public use of our data?
- What are the missing opportunities?
- What are the key needs?
- How do we best utilize all of the data we have, whether it is in systems that we manage within the Injury Center or in other major systems or major databanks, in order to set our priorities, objectives and goals and to better develop effective prevention strategies?

Those are some of the questions that NCIPC is thinking about, and it seems very important to engage with the BSC now to ensure that NCIPC is listening and that the major issues are “on the table” as they embark on the next steps with this portfolio review. It was his understanding that the next steps would be to identify and convene a workgroup with representatives from divisions and offices throughout NCIPC to start thinking about and framing the breadth and

depth of this topic and the portfolio review, which would include an evaluator from DARPI. Perhaps consideration should be given to including a BSC member, which would allow more BSC input up front and along the way as NCIPC moves through the portfolio review. He understood after the workgroup convenes they would begin thinking about identification of appropriate questions and steps in the process for the portfolio review, and would then have an expert panel convened by a BSC member as the chair to review the workgroup report, and that expert panel would then make recommendations. Eventually that report and recommendations would go back to the BSC to review. With that framing of where NCIPC is and what they are thinking about, Dr. Williamson opened the floor for thoughts, input, and guidance.

Discussion Points

Dr. Hargarten said he thought the data questions and issues were significant. He wondered whether if in framing this review they should perhaps be thinking about it in terms of advancing the science of the data, surveillance challenges, and data gaps that are not guiding the scope and nature of injury and violence. That is an “advancing the science question,” but he wondered about how the data are creatively disseminated in a way that captures leaders, civil society, policy leaders, local organizations, trauma centers, et cetera such that the data are informing to the key local decision makers who advance efforts to reduce the burden. He emphasized that he was not suggesting fabricating or misuse of the data. He suggested considering engaging the Gates Foundation where there was a presentation he attended in which a gentleman was talking about presenting data in a dynamic way, or in a way that really helps advance what everyone wants to see happen. He thought some of them were present when Dr. Annest discussed how the data in WISQARS could be more dynamically obtained. These are the exciting things that should be considered in this portfolio analysis. Advancing the science of surveillance is a huge strength of CDC, but advancing the dissemination of data in a really dynamic, creative way and pulling in sectors like foundations might be a real timely, useful exercise and provide a set of recommendations that would be useful as well.

Dr. Degutis thanked Dr. Hargarten for the suggestion, because she thought that was an area they have been challenged by the OD to assess in terms of how to push data out effectively so that it can be used to advance public health as opposed to waiting for people to ask for the data. She thought some of the ideas about engaging the Gates Foundation and others who have engaged in creative efforts would be a good direction. It is more about how the data are presented and disseminated and less about taking a deep dive into the state datasets themselves.

Dr. Williamson strongly agreed with Dr. Hargarten that it was about how they frame the interpretation and communication messages and present the data.

Dr. Fowler inquired about the timeline for the next portfolio review.

Dr. Williamson responded that the intent was to convene the committee within the next month or two. **Dr. Greenspan** added that they have an 18-month contract, which gives them basically 18 months to complete the next portfolio review.

Dr. Fowler went on record to congratulate NCIPC for the systematic way in which they are conducting the portfolio reviews and using the recommendations from the reviews, and she said she thought they were really setting an example for CDC. She asked whether Dr. Degutis wanted to say anything about the World Injury Conference during the remaining time. She noted that this seemed like such a missed opportunity for NCIPC.

Dr. Degutis indicated that NCIPC had been working with Johns Hopkins and Emory Universities to plan for the World Injury Conference in 2014 in Atlanta. Some challenges that have occurred government-wide and certainly HHS-wide have contributed to the fact that NCIPC is not able to serve as a co-sponsor for that conference. As a result, NCIPC has gone back to the World Health Organization (WHO) and the International Organizing Committee (IOC) to let them know. This has been a tremendous disappointment for NCIPC, but they are rethinking what is going to happen, and there is a meeting with the collaborating centers and the IOC in December 2013 in Geneva where they will be discussing the next steps for the next World Conference. She acknowledged that it was a missed opportunity, and that NCIPC was really looking forward to the conference and was very disappointed.

Dr. Fowler suggested talking offline about this at another time.

Dr. Gorman-Smith requested that Dr. Degutis offer further information about why NCIPC was not able to serve as a co-sponsor for the conference.

Dr. Degutis replied that part of it was that there are a lot of new rules about going through conference approval processes because of some of the missteps of other federal agencies. NCIPC submitted an application to obtain approval through HHS because of the scope of the conference, the number of attendees, and the cost. They certainly had support from two partners, Emory and Johns Hopkins Universities, as she mentioned. Basically, the application did not get pushed up by the Director's office at CDC to HHS for approval. There has been significant cutback on approval of any sponsorships of conferences as far as CDC is concerned. There are certainly issues with funding, costs, and how things are being paid for, particularly with the budgets being cut and the continued issues with sequestration. NCIPC did not have a lot of options. When they began, it looked good, but things changed in the meantime.



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 opened the floor for public comment at 11:27 am and invited anyone who wished to make comments to do so at this time. No public comments were offered at this time.

Conclusion and Adjourn

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 thanked everyone again for their participation, feedback, and insightful comments over the course of the meeting and called for any announcements. With none offered, she thanked those who planned and organized the meeting, including Dr. Gwen Cattledge, Ms. Tonia Lindley, and Ms. Shawn Cooper from TCG Consulting. She offered special thanks to the BSC's Writer/Editor, Stephanie Wallace, who has always done a wonderful job in capturing the content and discussion, and for doing so again during this meeting. After reminding participants to email Ms. Lindley at imx9@cdc.gov by the end of the day to confirm their attendance, **Dr. Fowler** wished everyone a happy and joyful holiday season, and officially adjourned the twelfth meeting of the NCIPC BSC at 11:31 am.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the November 15, 2013 NCIPC BSC meeting are accurate and complete:

February 17, 2014

Date



Carolyn Cumpsty Fowler, PhD, MPH
Chair, NCIPC BSC

Attachment A: Acronyms Used in this Document

ACA	(Patient Protection and) Affordable Care Act
ADS	Associate Director for Science
AHRQ	Agency for Healthcare Research and Quality
APA	American Psychological Association
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CM	Child Maltreatment
CMS	Centers for Medicare and Medicaid Services
CR	Continuing Resolution
DARPI	Division of Analysis, Research, and Practice Integration
DASH	Division of Adolescent School Health
DFO	Designated Federal Official
DOJ	(United States) Department of Justice
DUIP	Division of Unintentional Injury Prevention
DVP	Division of Violence Prevention
EMS	Emergency Medical Services
ERPO	Extramural Research Program Office
FOA	Funding Opportunity Announcement
FY	Fiscal Year
HHS	(United States Department of) Health and Human Services
HRSA	Health Resources and Services Administration
OD	Office of the Director (CDC)
IOC	International Organizing Committee
IOM	Institute of Medicine
IPV	Intimate Partner Violence
JAH	Journal of Adolescent Health
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
NCEH	National Center for Environmental Health
NCIPC	National Center for Injury Prevention and Control
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NIOSH	National Institute for Occupational Safety and Health
NISVS	National Intimate Partner and Sexual Violence Survey
NVDRS	National Violent Death Reporting System
OD	Office of the Director
PEPFAR	President's Emergency Plan For AIDS Relief
PRR	(Medicaid) Patient Review and Restriction (Program)
RFA	Request for Funding Announcement
SAMHSA	Substance Abuse and Mental Health Services Administration
SV	Sexual Violence
TBI	Traumatic Brain Injury
US	United States
VIPP	(Core State) Violence and Injury Prevention Program
WHO	World Health Organization
WISQARS	Web-based Injury Statistics Query and Reporting System