# Board of Scientific Counselors NCIPC
# Open to the Public
# August 23, 2022

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

# Contents

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

Forty-First Meeting
August 23, 2022

Virtual / Zoom Meeting
Open to the Public

## Summary Proceedings

The Forty-First meeting of the Board of Scientific Counselors (BSC) National Center for Injury Prevention and Control (NCIPC) was convened on Tuesday August 23, 2022 via Zoom and teleconference. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). BSC NCIPC Co-Chair, Dr. Amy Bonomi, presided.

## Opening Session

### Call to Order

**Amy Bonomi, PhD, MPH**
**Chair, NCIPC BSC**
**Founder, Social Justice Associates**
**Affiliate, Harborview Injury Prevention Research Center**
**University of Washington**

**Dr. Bonomi** officially called to order the Forty-First meeting of the NCIPC BSC at 11:00 AM Eastern Time (ET) on Tuesday, August 23, 2022.

### Roll Call / Meeting Process

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

**Mrs. Lindley** conducted a roll call of NCIPC BSC members and *Ex Officio* members, confirming that a quorum was present. Quorum was maintained throughout the meeting. No conflicts of interest (COI) were declared. An official list of BSC member attendees is appended to the end of this document as Attachment A. Mrs. Lindley introduced Stephanie Wallace, the Writer/Editor from Cambridge Communications and Training Institute (CCTI), who she explained would record the minutes of the meeting. To make it easier for her to capture comments, Mrs. Lindley requested that everyone state their names prior to any comments for the record. She indicated that the CDC and On Par Production (OPP) Technicians would audio record the meeting for archival purposes to ensure an accurate transcript of the meeting. The meeting minutes will become part of the official record and will be posted on the CDC website at www.CDC.gov/injury/bsc/meetings.html. All NCIPC BSC and *Ex Officio* members were requested to send an email to Mrs. Lindley at ncipcbsc@cdc.gov at the conclusion of the

meeting stating that they participated in this meeting. In addition, Mrs. Lindley explained the public comment process.

**Welcome**

**Amy Bonomi, PhD, MPH**
**Chair, NCIPC BSC**
**Founder, Social Justice Associates**
**Affiliate, Harborview Injury Prevention Research Center**
**University of Washington**

**Dr. Bonomi** expressed appreciation to the NCIPC BSC members for their time and commitment to injury and violence prevention and for taking time out of their busy schedules to participate on this important committee that provides advice to CDC and NCIPC on its injury and violence prevention activities. She also thanked and welcomed members of the public, pointing out that there would be a Public Comment session from 1:00 PM to 1:15 PM. At that time, Mr. Victor Cabada would be providing instructions for anyone wishing to make a public comment. Dr. Bonomi referred those joining by phone without access to the slides through Zoom to www.cdc.gov/injury/BSC where the slides could be downloaded.

**Approval of the April 11, 2022 NCIPC BSC Meeting Minutes**

**Amy Bonomi, PhD, MPH**
**Chair, NCIPC BSC**
**Founder, Social Justice Associates**
**Affiliate, Harborview Injury Prevention Research Center**
**University of Washington**

**Dr. Bonomi** referred BSC members to the copy of the minutes provided to them with their meeting materials from the April 22, 2022 NCIPC BSC meeting. With no questions or edits noted, Dr. Bonomi called for an official vote.

**Motion / Vote**

**Dr. Floyd** made a motion to approve the April 22, 2022 NCIPC BSC meeting minutes. **Dr. Liller** seconded the motion. The motion carried unanimously with no abstentions or dissentions.

## Director's Update

**Christopher Jones, PharmD, DrPH, MPH**
**CAPT, US Public Health Service**
**Acting Director, National Center for Injury Prevention and Control**
**Centers for Disease Control and Prevention**

**CAPT Jones** thanked everyone for joining the meeting. NCIPC continues to rely on the BSC's feedback and advice to help guide its work and appreciates the formal and informal engagements, continued review of the Injury Center's extramural research, and engagements in regular BSC meetings to provide feedback on some of NCIPC's research priorities. He provided a few updates on activities within the Injury Center. There was a lot of information reported about CDC the previous week based on a series of assessments, one of which was specific to COVID-19 and another that was more broadly looking at CDC's structure across diseases and systems and how best to move the agency forward to continue to meet its public health mission. As was provided in information from Dr. Walensky, the purpose of these assessments is to continue to ensure that CDC can be nimble and actionable with a specific focus on its core capabilities (e.g., data, laboratory, science, policies, communication) all in the service of public health action and moving to an action-based framework. This is great news for the Injury Center, which already has been moving in that direction over the last several years—first with NCIPC's overdose data to action work and more recently with its violence prevention and suicide prevention work in terms of trying to marry data to drive action and identify risk, how risk is changing, who is impacted, and how best to deploy strategies to address the identified challenges. It also builds on NCIPC's ongoing efforts pertaining to data modernization and using innovative data science tools, methods, and techniques to advance the Injury Center's injury and violence prevention work. There are many more specifics to come about the overall CDC reorganization and process changes, but from the Injury Center's perspective, the changes that are occurring at the agency are likely to have a minimal impact on NCIPC's structure or function as a center. It will create some efficiencies as an agency, and streamline some activities, but NCIPC's core mission and structure are not changing. Additional information on this effort will be shared with the BSC as it becomes available.

A limited reorganization has been underway within NCIPC. In 2018 and 2019, the Injury Center went through a large reorganization that created the current structure. NCIPC recognized that for some of its divisons, particularly the Division of Overdose Prevention (DOP) and the Division of Violence Prevention (DVP), some structural changes needed to be made to ensure that they could continue to meet demands, allocate resources, and advance violence and overdose prevention science and practice in an efficient manner. That reorganization was approved within the last couple of months and NCIPC is moving toward a new fiscal year (FY) launch date on October 1, 2022.

In terms of the Injury Center's Diversity, Equity, Belonging, Inclusion, and Accessibility (DEBIA) work, the BSC has provided rich feedback on how NCIPC can advance equity in its scientific and programmatic work and think about equity as an organization. The Injury Center has been on about a 1.5-year journey to engage in introspection with respect to DEBIA and to think about how to truly integrate equity into NCIPC's scientific and programmatic work. The Injury Center has taken some actions recently to bake that into who we are as an organization. First, 2 new senior leadership positions were created within NCIPC. The first is a DEBIA Advisor who will focus on leading and coordinating NCIPC's workforce and workplace activities with respect to internal-facing efforts. The second is a Health Equity Officer who will lead and coordinate the work pertaining to scientific and programmatic aspects of injury and violence prevention. To

help facilitate and build out that structure, each of NCIPC's divisions has been asked to hire a Senior Health Equity position that also can help coordinate and work with the DEBIA Advisor and Health Equity Officer across the Injury Center to realize NCIPC's strategic plan goals that were released at the end of 2021.

Two scientific publications that have shone a light on issues related to equity and disparities are the May 2022 *Vital*signs™ titled, "Vital Signs: Changes in Firearm Homicide and Suicide Rates — United States, 2019–2020"[1] that clearly documented widening of disparities among certain racial and ethnic populations for firearm homicides in particular and persistently high rates of firearm suicide. In July 2022, NCIPC released a *Vital*signs™ on overdose during the COVID-19 pandemic titled, "*Vital Signs*: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020."[2] This report highlighted social determinants of health (SDOH) among non-Hispanic Black persons and non-Hispanic American Indian/Alaska Native (AI/AN) persons who have been disproportionately impacted by overdose in the last several years. This reports also discussed the connection between income in equality and increases in overdose that cut across racial and ethnic groups. These reports are reflective of NCIPC's commitment to try to shine a light where there are disparities and inequities in injury and violence prevention, and to bring to bear the evidence and solutions to address those disparities.

In terms of the day's agenda, CAPT Jones expressed his excitement to get the BSC's input on NCIPC's new research priority on drowning and an update on the existing priority of motor vehicle (MV) injury prevention. Given that these areas are increasingly receiving focus, NCIPC wants to continue to build out a public health response for them. The BSC can help hone in the highest priority research that NCIPC needs to be conducting and advancing in the field, which will be critical to support those efforts.

In closing, CAPT Jones expressed his gratitude to the BSC members for continuing to serve. NCIPC greatly appreciates the members' time and energy in terms of meeting attendance and providing feedback, advice, and recommendations.

## Discussion Points

**Dr. Compton** said he was reading a major article in the *New York Times* earlier in the day about increasing traffic accidents, particularly during the pandemic. While that clearly is an issue for the National Highway Traffic Safety Administration (NHTSA), he wondered whether it also is an issue for the Injury Center. To the extent that the evidence points toward drug-impaired driving, the National Institute on Drug Abuse (NIDA) would be delighted to work with NICIPC on some of these priorities.

**CAPT Jones** indicated that NCIPC has a Transportation Safety Team that has a long history of work on MV safety. This is an area that NCIPC is increasingly concerned about, given some of the trends that have been occurring and reversals of what were multiple years of declines in fatalities related to MV traffic crashes. With the Infrastructure Bill, there was greater focus on MV safety and it reenergizes CDC and NHTSA in their work. Part of that bill also calls out CDC to work with NHTSA to advance data, surveillance, and public health strategies. Under Dr.

[1] Kegler SR, Simon TR, Zwald ML, et al. Vital Signs: Changes in Firearm Homicide and Suicide Rates — United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:656–663. DOI: http://dx.doi.org/10.15585/mmwr.mm7119e1external

[2] Kariisa M, Davis NL, Kumar S, et al. Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:940–947. DOI: http://dx.doi.org/10.15585/mmwr.mm7129e2

Frieden, MV safety was a “Winnable Battle,” so it had more visibility. It is a priority for NCIPC, and an increasing one, given some of the trends occurring.

**Dr. Kaplan** added the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to the list of potential partners for NCIPC.

## Motor Vehicle Injury Prevention (MVIP) Priorities Update

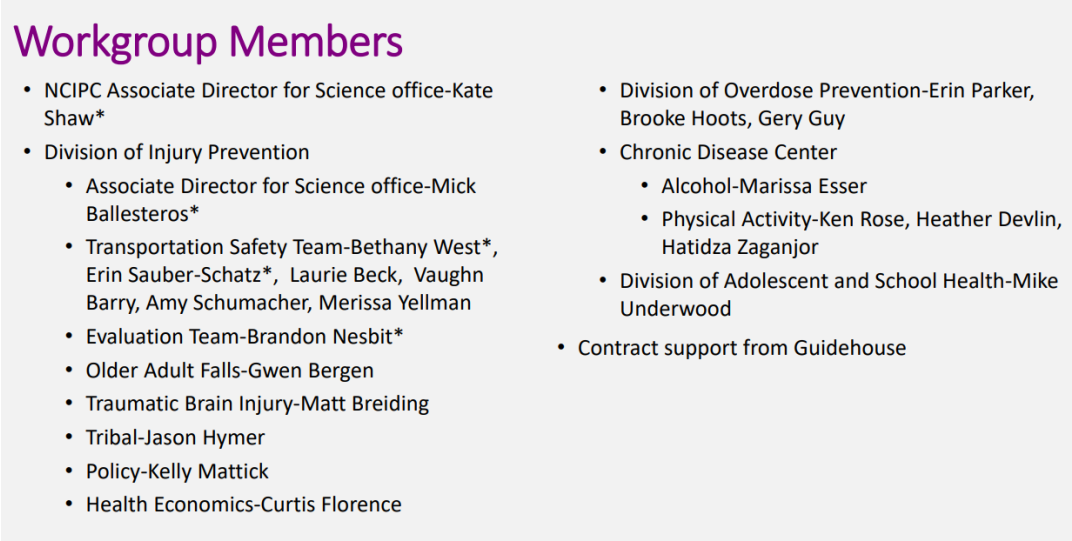
**Ms. Bethany West, Acting Team Lead**
**Transportation Safety Team, Division of Injury Prevention**
**National Center for Injury Prevention and Control**
**Centers for Disease Control and Prevention**

**Ms. West** discussed NCIPC’s process to update its research priorities for MVIP and reviewed the draft high-level research priorities that will guide the Injury Center’s work for the next 3 to 5 years. The goal of this activity was to assess NCIPC’s MVIP research efforts and update the Center’s MVIP Research Priorities. To orient everyone, Ms. West first reviewed the previous priorities from 2015, which were to:

1. Assess the effectiveness of policies and program strategies for preventing or reducing alcohol- and drug-impaired driving (ADID).
2. Evaluate the effectiveness of behavioral, environmental, and policy approaches for increasing restraint use.
3. Evaluate strategies for reducing disparities in motor vehicle injuries and deaths among high-risk groups and minority populations.
4. Identify strategies that increase the safe transportation of older adults through research on stages of mobility transition and how to increase the use of supplemental transportation systems.
5. Identify factors that influence state variations in motor vehicle injury and death rates by improving the quality, availability, and use of linked data for decision-making.

The Injury Center Associate Director for Science (ADS) Office identified an overall process that included the first step of setting the guiding principles and scope. Next, a workgroup (WG) was established and roles were identified for members. The next step was to gather and review materials to evaluate NCIPC’s progress on the 2015 research priorities and also to establish gaps in the field that can be addressed by the new MVIP research priorities. This was accomplished by creating an inventory of NCIPC intramural and extramural MVIP research, conducting interviews with external and internal MVIP experts, conducting a literature review of the MVIP research field, performing an environmental scan of federal agency and partner research. From this, the findings were synthesized by the WG and new priorities were drafted.

It is important to note that the guiding principles and scope set by the ADS Office covers MVIP research and does not cover any other activities that the Transportation Safety Team undertakes, such as surveillance and other non-research activities. The guiding principles and scope include the final product of a new set of priorities and a set of more specific research questions under each priority. These research questions are expected to guide NCIPC’s work for the next 3-5 years and include both intramural and extramural projects. A priority was placed in areas where it is thought that there is an opportunity to demonstrate progress. As mentioned, a key step was to take a look back at what has been accomplished singe the 2015 priorities. The WG members are shown below, with the leads designated by an asterisk:




The following evaluation questions were identified by the WG and were used as a touchpoint throughout the process:

- ❑ Are there existing research gaps/needs from CDC's 2015 MVIP research priorities?
- ❑ How has the MVIP landscape changed since 2015?
- ❑ Have emerging research issues related to MVIP surfaced?
- ❑ What of the new research priorities rises to the top for immediate focus?
- ❑ What are the largest gaps in the MVIP field that research efforts should focus on for the next 5 years?
- ❑ What is CDC's unique contribution to the MVIP research field?
- ❑ What is CDC's unique role in the federal landscape of MVIP research?
- ❑ What, if anything, does CDC need to change?
- ❑ What are the current needs of MVIP practitioners that can be informed by new/updated research?

There were 4 main steps to the process of updating NCIPC's research priorities, which were to: 1) compile and analyze an inventory of NCIPC's intramural and extramural MVIP research publications; 2) conduct and summarize key findings from a series of interviews with MVIP research experts, internal and external to CDC; 3) review literature of MVIP field and environmental scan of federal agency and partner webpages for reported research; and 4) synthesize findings across the inventory, interviews, literature review, and environmental scan and documenting insights for updated MVIP research priorities.

For the first step of compiling and analyzing the inventory of NCIPC projects, the WG gathered and reviewed materials in intramural and extramural research that has been conducted since the 2015 priorities. Of note, prior to the Injury Center's reorganization in 2019, the Transportation Safety Team was in the Division of Unintentional Injury Prevention (DUIP). Therefore, the bibliographies were pulled from both DUIP and the current Division of Injury Prevention (DIP). There are a number of internal tracking systems at the center, division, and team levels and there is considerable overlap between these systems. In reviewing all of them, the WG was able to obtain a comprehensive picture of what was done. In terms of synthesizing the findings, 41 of the 113 projects and papers initially identified were excluded because they were duplicates or non-research (e.g., book chapters, surveillance, commentaries, recommendations). After removing the duplicates and non-research items, the

WG included the remaining 72 publications that were focused on original research published by CDC authors. This table shows the number of extramural and intramural projects identified by research priority:

| 2015 Research Priority* | Extramural | Intramural |
|---|---|---|
| P1: Alcohol- and Drug-Impaired Driving | 10 | 13 |
| P2: Restraint Use | 4 | 13 |
| P3: Disparities | 7 | 15 |
| P4: Older Adult Mobility | 9 | 7 |
| P5: Data Linkage | 4 | 3 |

*Research activities may address more than one research priority

With regard to the second step to conduct expert interviews with a wide variety of MVIP experts, including those at other federal agencies, the goals were to:

- ❑ Understand how the MVIP field has changed in the past five years
- ❑ Assess the understanding of CDC's role in advancing MVIP research
- ❑ Reflect on whether adequate progress has been made towards the 2015 MVIP research priorities
- ❑ Describe potential gaps present in NCIPC research agenda and field
- ❑ Provide insight on which MVIP research questions should be the focus of NCIPC research for the next 5 years

The MVIP expert interviews included subject matter experts (SMEs) from across the Department of Health and Human Services (HHS); other federal agencies such as the NHTSA and the National Transportation Safety Board (NTSB); and external partners such as the Insurance Institute for Highway Safety (IIHS), National Safety Council (NSC), Former CDC staff (retired), Johns Hopkins University (JHU), Columbia University, Transportation Research Board (TRB), Bloomberg Philanthropies, and the Fédération Internationale de l'Automobile (FIA) Foundation. The WG synthesized the expert interviews and identified a recommended set of areas of focus to: 1) position NCIPC as a leader in researching health disparities and promoting health equity in MVIP; 2) continue researching and supporting evidence-based MVIP strategies; 3) address emerging issues related to impaired driving; 4) continue to monitor for and address new and existing issues related to mobility and access; and 5) improve quality, availability, and use of linked data for decision-making.

The third step in the overall process was to conduct a larger literature review with a focus on review articles or articles that addressed gaps in the MVIP research field. This literature review focused on review articles as there was not time to perform a full review of individual published studies. The WG synthesized the findings across the inventory, the interviews, and the literature review. This literature review highlighted that there are still research gaps in these topic areas within MVIP: Impaired Driving, Restraint Use, Older Adults, and Health Equity. Insights from these findings informed NCIPC's proposed updated MVIP research priorities and main research questions identified, which are as follows:

**<u>Impaired Driving</u>: Understand differences in and prevention strategies for impaired driving (i.e., alcohol-, drug-, and polysubstance- impaired) especially among populations disproportionately affected by impaired driving.**

1. What are the risk and protective factors for driving while impaired, and how do these differ among sub-groups of the population?
2. What are the population- and setting-specific barriers and facilitators to not driving while impaired?
3. In what ways do different substances (e.g., cannabis, opioids) alone or in combination (polysubstance use) impact driving behaviors and motor vehicle crashes, injuries, and deaths?
4. What strategies are effective for the prevention of alcohol-, drug-, and/or polysubstance-impaired driving in the current landscape, and does the effectiveness and acceptability of strategies to prevent impaired driving vary by demographic groups and settings?

**<u>Restraint Use</u>: Examine key factors and effective strategies for increasing consistent and proper restraint use.**

1. How do those who never, sometimes, and always use seat belts differ by characteristics such as age, sex, race/ethnicity, geographic location, seating position, and reasons for using seat belts?
2. What are barriers and facilitators to consistent restraint use among sub-groups of the population at higher risk of inconsistent restraint use (teens/young adults, people living in rural areas, people of certain races/ethnicities)?
3. What unique risk and protective factors, as well as the population- and setting-specific barriers and facilitators (e.g., child restraint laws), contribute to health inequities in premature graduation (e.g., prematurely moving from a booster seat to a seat belt) for child passengers, and how do these differ among sub-groups of the population and SDOH?

**<u>Older Adult Mobility</u>: Identify risk and protective factors and effective strategies for reducing transportation-related injuries among older adults while preserving their mobility and increasing safe transportation.**

1. What are the risk and protective factors for MVC injury risk among older adults, and how do these differ among sub-groups of the population, including but not limited to race/ethnicity, health conditions, and road user type?
2. What risk and protective factors contribute to health inequities in transportation access and mobility access among sub-groups of older adults?
3. Among older adults, what are the shared, modifiable risk and protective factors for MVC and fall injuries and how do these vary and contribute to health inequities by age, sex, race/ethnicity, SDOH, or location? How can these shared factors be used to inform future prevention activities to improve health equity for both MVC and fall injuries?
4. To what extent are healthcare providers aware of and willing to recommend strategies (e.g., medication safety) that promote older driver safety?

**Emerging or Evolving Trends**: **Better understand risk factors for new, emerging, or evolving trends in transportation safety including prevention of pedestrian injuries and deaths (Involves working with partners to link crash data and injury health data, including NHTSA).**

1. What risk and protective factors explain MVC-related pedestrian injury rates?
2. To what extent does the implementation of traffic safety policies and roadway design countermeasures (e.g., crosswalks, roundabouts, variable speed limits, etc.) positively or negatively impact equity?

**Discussion Points**

**Dr. Floyd** commended the focus on the older population in terms of driver safety. As a clinician who deals with this regularly with his patient population, he emphasized the importance of prioritizing training for clinicians on how to assess and work with patients on driver safety. He had zero training in medical school in residency. As a clinician, it is one of the most painful and difficult discussions to have with patients because of the loss of independence that this entails. From the public safety perspective, he also recommended that NCIPC examine the impact of conflicting laws on this. He was shocked to learn a number of years ago when he was at a conference that if a clinician reports a patient to the Department of Motor Vehicles as being an unsafe driver, at least in New York, it could expose the clinician to a Health Insurance Portability and Accountability Act (HIPAA) violation. He subsequently confirmed this with the legal department at his facility, which confirmed that this is correct. There needs to be review and clarification of such laws, as well and streamlining of regulations.

**Dr. Pacula** observed that the new priorities were fairly aligned with the old priorities, with a small step further. This is not necessarily a bad thing, but she thought there was something missing from the first set of priorities that will play into the second set of priorities, particularly with regard to research on impaired driving. One of the priorities that is necessary in order to answer many of the research questions posed, there needs to be good data on testing of people who are injured in crashes. In the Fatality Analysis Reporting System (FARS) data, there are major inconsistencies across states in terms of testing rates, who is tested, under what conditions, using what testing techniques, and how they get coded. A clear understanding of the data-generating process and a requirement of states to make that information known would be useful for the research that is conducted in these areas. She thinks that CDC can have some sway in influencing how data are being reported and in order to improve the data to enhance research in this area.

**Dr. Kaplan** noted that there seems to be a conspicuous absence in general in terms of vehicle accidents and cycling. While cycling is growing through the country, he did not hear anything in the priorities on cycling. Many cities are promoting cycling, but research has shown that the number of injuries occurring among cyclists are increasing and some are fatal. He asked whether cycling fits into the priorities and if there is bias towards automobiles.

**Ms. West** replied that when they assessed NCIPC priorities and looked at burden, there were over 7,000 pedestrian deaths and about 700 cyclist deaths in their most recent data. While each of those 700 deaths is tragic and impacts families and communities, NCIPC has to leverage its resources with where they can make the biggest improvements in the next 3 to 5 years. One of DIP's sister divisions in the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) does a lot of work pertaining to the built environment and cycling. NCIPC also wants to be aware of other groups within CDC that are working in the

spaces the Injury Center might not be able to cover within the Transportation Safety Team to ensure that they are complementing each other. NCIPC is interested in helping to prevent injuries and deaths among vulnerable users, including cyclists. It may just not be as visible in these research priorities.

**Dr. Michael** stressed that NCIPC has been a leader for a long time and serves a very important role in that respect. The comprehensive review of the priorities was timely and very important. Specifically, he was glad to see the consideration of infrastructure factors in the pedestrian area. He asked whether the CDC has or is willing to consider infrastructure or other structural interventions in the other priority areas within MVIP. In the context of current events, there is growing interest globally and now in the US in the Safe System approach to roadway injury control. This is largely based not at the individual level, but in the environment in which individuals live and move around. Also timely is the new $1 billion per year program administered by the US Department of Transportation (DOT) for the Safe Streets and Roads for All (SS4A), which is infusing a lot more resources specifically into infrastructure changes consistent with the Safe System approach. This provides an environment in which new research and evaluation could be leveraged and have great impact. Another specific contextual factor is that as part of the new infrastructure law, there is a landmark new federal requirement for a federal motor vehicle safety standard to be developed in the next 3 years mandating impairment detection technology in every new vehicle by approximately the end of the decade. That type of technology has been estimated to reduce alcohol-impaired driving by as much as 90% and to save about 9,000 lives per year. No other interventions have come close to that. He asked whether there is openness, willingness, interest in looking at infrastructure and structural changes for the other priority areas.

**Ms. West** indicated that they have worked on other initiatives to guide NCIPC's work for the next 3 to 5 years, including the strategic plan. There is more on a Safe Systems approach in NCIPC's strategic plan than she showed in these high-level research questions within the priorities. In partnership with NCIPC's sister center, NCCDPHP and its built environment work, they are working with 2 SS4A communities to help advise them and help them with the federal match.

**Dr. Compton** seconded Dr. Pacula's encouragement for better data. The FARS system has been notorious for having gaps related to illicit substances. The data are not missing at random, so they have impeded the ability to conduct full-scale, national research on some of these questions. If there is a role for CDC in helping to change that, it could lead to tremendous improvements in the ability to explore and uncover new ways to address driving injuries related to illicit substances. He also was struck that while the priorities seemed very reasonable, he did not hear much in the area of distracted driving and how that might intersect with some of the factors that were listed. While there are plenty of others such as NHTSA focusing on that issue, he wondered if there might be interactions with some of the priorities Ms. West highlighted. He was thinking particularly about substance use, which in combination with distractions from cell phones and the like might play a particular role if the details of it could be understood.

**Ms. West** agreed that better data are needed and noted that there are potentially other ways to obtain those data that are more overarching than just impaired driving. NCIPC remains cautiously optimistic that this will come to fruition. NCIPC's federal partners have sent them a lot of work in the distracted driving space and they do have conversations with others to ensure that their priorities are complementary and not duplicative.

**Dr. Liller** said she was glad to see that MVIP was still being considered as much as it is. As they have heard, CDC has been a leader in this area. She wondered whether CDC has considered emerging issues as a potential research focus for the future. Motorcycle and electric scooter injuries and deaths are still quite prominent. An emergence of scooter injuries has occurred as increasing numbers of people are using scooters as a transportation source, and there are issues because there are no rules about them. The rate of these injuries is exceeding motorcycle injuries now. Other modes of transportation represent an important issue to address in the future.

**Ms. West** indicated that NCIPC has done some work on scooters in the past and they maintain some high-level research on motorcycle safety.

**Dr. Greenspan** thanked all of the BSC members for their comments and Ms. West and the WG for all of their work in this area in terms of resetting the priorities. One thing she thinks NCIPC struggles with as a center is how they prioritize what they are going to be doing in the next 3 to 5 years and where they can make the most important impacts. Some of these decisions are made based on the information they have, but she invited the BSC members to provide their thoughts about whether NCIPC should be placing other issues at a higher level of prioritization than the current priorities. Given the Injury Center's resources, if they prioritize something else, it may mean not prioritizing one of the other things they have mentioned for the next 3 to 5 years.

**Dr. Kaplan** pointed out that much of what he heard regarded drug-related distractions, but there are other types of distractions. For instance, he drives an older automobile that is low-tech with few distractions. In a new car with emerging technologies, he is extremely distracted and wonders what impact that is having on his driving. He thinks there needs to be more emphasis on the dangers of emerging technologies, given that there is a lot going on inside of newer cars (e.g., all of the technology on the dashboard, movies in the backseat, et cetera).

**Dr. Lumba-Brown** noted that looking through impaired driving the CDC website, she noticed that the public-facing content is focused on the alcohol-impaired driver. A good way forward would be to consider taking a closer look at how "impaired" and "distracted" driving are defined, perhaps thinking of those as two faces of a coin and looking at efforts in prevention of impaired and distracted driving in general, with a focus on the public recognizing when they have a cognitive impairment (e.g., alcohol, illicit drug use, and other factors). That could be an important new direction that moves away from the focus on exactly what is causing the impairment, whatever that might be among many potential things that can cause impairment and distraction.

**Dr. Michael** observed that a question that has emerged over the last couple of years is the present situation and future of law enforcement-based interventions for MVIP, such as high-visibility enforcement programs that CDC's Community Guide has pointed to as one of the most effective for areas such as impaired driving and seatbelt use. The emerging questions about the future of such law enforcement interventions regard their feasibility given workforce issues among law enforcement and the equity issues that have been raised with regard to traffic law enforcement. These are serious questions that affect the future viability of the currently leading interventions in these important areas. CDC is well-positioned to conduct a rigorous review to take a critical look at the future viability of law enforcement programs in areas such as impaired driving and restraint use.

**Dr. Pacula** said that the discussion on priorities prompted her to seek information from the CDC regarding the relative impact and significance in terms of deaths. She was struck that distracted driving was substantially lower in terms of the statics and annual deaths as compared to impaired driving. This made her wonder to what extent there is good measurement of distracted driving. In terms of priorities, CDC can look at the indicators they have and assess the reliability of the indicators they are using. If these numbers are good and high quality, then focusing on impaired driving over distracted driving makes sense. The scientists at CDC are quite capable of doing this, so she encouraged taking a look at the data generating process that is guiding decisions.

**Dr. Bonomi** recapped some priorities she heard: 1) evaluating the impact of multiple distractions, including specifically assessing the quality/reliability of the measurements; 2) assess cognitive impairments, including alcohol and other multiple cognitive impairments that might be impacting individuals; and 3) examine the feasibility, equity, and appropriateness of law enforcement interventions.

## Drowning Prevention Research Priorities

**Dr. Tessa Clemens, Health Scientist**
**Safety Promotion Team, Division of Injury Prevention**
**National Center for Injury Prevention and Control**
**Centers for Disease Control and Prevention**

**Dr. Clemens** explained that the overall process for developing the draft research priorities for drowning prevention was similar to the process used for development of the MVIP priorities. However, there were some differences because drowning prevention in its current form is a relatively new program at CDC and there were no prior research priorities to update. Dedicated staff began working on drowning prevention at the end of 2020, who basically started from scratch with the creation of the strategic plan for drowning prevention. The overall process for development of the drowning research priorities included developing the guiding principles and scope, gathering and reviewing materials that included compiling an inventory of NCIPC projects and conducting a landscape review for drowning prevention in general, synthesizing the findings of that effort, and then drafting the proposed research priorities for drowning prevention based on those efforts.

In terms of the guiding principles and scope, the priorities are intended to cover 5 years of NCIPC's drowning program and to include intramural and extramural projects and the ability to demonstrate progress in the research priorities over the next 5 years. Available resources and capacity were major considerations in the development of the drowning prevention priorities. There also was a goal to focus on primary drowning prevention strategies as opposed to rescue and resuscitation. Although NCIPC provides some technical assistance (TA) on global drowning prevention projects, the focus for these particular priorities is domestic drowning prevention.

Health equity has been foundational to NCIPC's drowning prevention work from the outset. It is known from previous studies that there are racial and ethnic disparities in drowning death rates in the US. A *Morbidity and Mortality Weekly Report* (*MMWR*) published in 2021[3] identified that although drowning rates among persons ≤30 years of age decreased overall from 1999-2019, racial and ethnic disparities persisted over this timeframe. A 5-year moving average in drowning disparity rate ratios during this time period by racial and ethnic group, using non-Hispanic White

[3] Source: http://dx.doi.org/10.15585/mmwr.mm7024a1

persons as a reference, drowning disparity rate ratios ranged from 1.8 to 2.2 for non-Hispanic AI/AN persons and from 1.3 to 1.6 for non-Hispanic Black or African American persons. The non-Hispanic Black to White rate ratio increased significantly from 2005-2019. The DIP recently published an article in the *Journal of Safety Research* (*JSR*)[4] that identified significant increases in drowning death rates in the US in 2020, with the largest increases among young adults, males, and Black or African American people. Rates increased 24% among Black or African American people in 2020 and drowning rates were 1.8 times higher among Black or African American people than White people during 2020.

Because of these persistent, and in some cases increasing disparities, health equity is a cross-cutting focus across all of the research priorities in drowning prevention and was a key guiding principle in the approach to developing these priorities. The WG for the drowning prevention research priorities is smaller than the WGs for other areas and was internal to NCIPC. One reason for the smaller group was that there was a condensed timeframe for development of the drowning research priorities, but they did have the external SME interview component and contract support from Guidehouse in development of priorities. Members of the WG include Mick Ballesteros, Tessa Clemens, Christopher Harper, Karin Mack, Briana Moreland, and Brendan Nesbitt.

The evaluation questions utilized by the WG were as follows:

- ❑ How has the drowning prevention research landscape changed in the last 5 years?
- ❑ What are the largest gaps in the drowning field that research efforts should focus on for the next 5 years?
- ❑ Have emerging research issues related to drowning surfaced?
- ❑ How do new and emerging drowning topics inform research priorities for drowning?
- ❑ What is CDC's unique contribution to the drowning research field?
- ❑ What is CDC's unique role in the federal landscape of drowning research?

Being an emerging research program, the last two questions were particularly important to the development of NCIPC's first set of research priorities in the area of drowning prevention. In terms of the methods, the literature review included a targeted review and summary of seminal drowning prevention articles. This was targeted to the existing domains on which CDC's drowning prevention program is focused. The research inventory involved compilation of NCIPC's previous drowning research. Because there has been limited work done on drowning prevention within CDC in the past, this compilation was focused on all-time, not just the past 5 years like some of the other topic areas. A partner scan was conducted that included a review of key drowning prevention partner organizations' research activities. In terms of capacity, an assessment was performed of NCIPC's current and planned capacity to conduct drowning prevention research. Interviews and focus group were conducted with drowning research experts and partners internal and external to CDC.

To highlight a few key findings of the literature review, the review revealed that there is a need to improve the understanding of drowning-related circumstances among disproportionately impacted persons (e.g., children, children with underlying health conditions, adolescents, men, Black or African American persons, AI/AN, and older adults). Multiple articles indicated that water competency, or basic swimming and water safety skills and training, is an effective primary drowning prevention approach for children and adolescents. However, there is a need to improve methodologies and develop more robust evaluations to measure water competency

[4] https://www.sciencedirect.com/science/article/abs/pii/S0022437522000883

skills training and population-level impacts of program implementation. There also are limitations with regard to fatal and non-fatal drowning surveillance published in the literature. More comprehensive data are needed to identify the true burden of drowning, circumstances of drowning, and the range of outcomes associated with non-fatal drowning. Lack of comprehensive drowning data hinders estimates of the social and economic burden of drowning.

With regard to the research inventory findings, 7 research articles were identified that were published between 1998-2014 and 7 recently published/current research projects were identified from 2021-present. The drowning prevention research domains and number of studies identified are shown in this table:

| Drowning Prevention Research Domain | # of Studies |
|---|---|
| Basic swimming instruction and water safety interventions for the prevention of drowning | 2 |
| Methods for improving surveillance data to enhance knowledge base of drowning-related risk and protective factors | 3 |
| Implementation science to improve the effectiveness and equitability of interventions among persons at disproportionate risk for drowning | 2 |

The partner scan found no direct overlap with NCIPC's drowning prevention research. Given the limited organizational presence in drowning prevention research, there is an opportunity for CDC to establish leadership in advancing primary prevention research and to collaborate with partner organizations. Interviews and focus groups were conducted with the following external and CDC SMEs:

**External SMEs**

- ❑ American Academy of Pediatrics (AAP)
- ❑ Diversity in Aquatics
- ❑ Safe Kids Worldwide®
- ❑ World Health Organization (WHO)
- ❑ Clinician scientists (trauma/emergency)
- ❑ Drowning research experts

**CDC SMEs**

- ❑ National Center for Environmental Health (NCEH)
- ❑ Healthy and Safe Swimming Program in the National Center for Emerging Zoonotic and Infectious Disease (NCEZID), which works primarily with waterborne diseases in public swimming pools and other recreational water bodies, but there is certainly overlap with drowning prevention
- ❑ Disaster preparedness colleagues
- ❑ NCIPC's Health Equity Office
- ❑ Previous drowning SMEs who contributed to publications during the 1998-2014 era

The findings from these interviews and focus group discussions were that CDC's role in drowning research should be to: 1) support the development and implementation of effective drowning prevention interventions; 2) address gaps in data collection and data linkage to better understand circumstances and burden of drowning; 3) improve efforts to address known racial/ethnic and sociocultural disparities in drowning; 4) emerge as the domestic leader in supporting research and guidance in drowning prevention; and 5) create greater opportunities for organizational collaboration.

Based on these efforts, the WG developed the following 3 proposed priorities in the area of drowning prevention research:

***Proposed Priority 1: Describe the risk and protective factors associated with fatal and non-fatal drowning with an emphasis on persons who may be disproportionately affected.***

1. What is the usefulness of existing data sources for reporting the burden, circumstances, and risk factors related to drowning (e.g., syndromic surveillance, hospital records, police records, lifeguard incident reports, data from Child Death Review Teams)?
2. How can innovative techniques (e.g., data linkage, machine learning) be employed to improve drowning surveillance and contribute to better understanding the circumstances of drowning?
3. How can analytic tools (e.g., Social Vulnerability Index) be employed to improve our understanding of drowning risk factors?
4. What risk and protective factors are related to differences in drowning rates among different groups (e.g., racial and ethnic minority groups, persons with low socioeconomic status, children with autism, children with underlying medical conditions)?

***Proposed Priority 2: Identify and evaluate effective strategies to prevent drowning among persons that are at increased risk of drowning.***

1. How can basic swimming and water safety skills most efficiently and effectively be taught to children and youth, including young children 1 to 4 years of age?
2. What are the most effective ways to increase adoption of environmental and equipment-related drowning prevention strategies (e.g., pool fencing and other barriers, lifejacket use, lifeguard supervision) and what is the role of policy/legislation to support these measures?
3. What individual, relationship, community, and societal factors serve as barriers and facilitators to willingness to adopt drowning prevention strategies (e.g., pool fencing and other barriers, lifejacket use), especially among disproportionately affected persons?

***Proposed Priority 3: Identify how to effectively and equitably implement basic swimming and water safety skills training among persons at increased risk of drowning.***

1. What are the barriers (including historical context and cultural considerations) to accessing basic swimming and water safety skills programs for persons at an increased risk of drowning and how can these barriers be overcome for effective program implementation?
2. What are the most effective ways to encourage youth and parents/guardians who are at an increased risk of drowning to participate in basic swimming and water safety skills training?
3. How can partnerships be leveraged to scale up basic swimming and water safety skills training programs among persons at increased risk of drowning?

## Discussion Points

**Dr. Liller** noted that living in Florida, she saw a lot of work in this area years ago. A lot of the research questions proposed look very similar to those from years ago, and drowning remains a serious problem. In Florida's current state health plan, there is an injury section in which drowning figures prominently. Florida is conducting a social marketing campaign, which CDC might want to consider in the future. A lot of the drowning prevention effort pertains to communication and messages in terms of what messages have been successful. Despite years of drowning prevention messages, drowning is still the leading cause of death (COD) for children 1 to 4 years of age across the country. Something is amiss with messaging, along with other issues CDC is trying to figure out. Florida is implementing this campaign by partnering with Airbnb, hotels, and other areas where tourists visit where drowning prevention strategies are not necessarily being enforced or parents/guardians are enjoying vacation and not paying close attention. She and the Florida Prevention Research Center (FPRC) are working with the Florida Department of Health on the campaign. They also set up messaging in airports, including central location intercept interviews. They are even assessing eye movement now. She thinks this campaign is going to lead to some exciting findings. They have done some journey mapping and there is a bilingual component. Policies, laws, and innovation technologies have been critical, but getting parents to listen to messaging and practice prevention strategies has been a dilemma. (Note-the campaign in Florida is now focused on residents and not tourists but the majority of methods described above are still being done with residents).

**Dr. Pecula** commented on how appreciative she was of the first question under Proposed Priority 1 pertaining to data, and emphasized the importance of understanding the data and quality of data for any type of strategy, evaluation, or surveillance.

**Dr. Greenspan** invited the BSC members to provide their thoughts about whether the proposed NCIPC priorities strike a good balance for the next 5 years between data collection and prevention strategies.

**Dr. Kaplan** observed that much of what he was hearing was confined to the US. However, the drowning rates are considerably lower in the European Union (EU) data than they are in the US. He has said many times that CDC needs to be looking for ways to collaborate with some of its European counterparts to understand what they are doing that is working. It is not necessary to "reinvent the wheel" in terms of finding more robust measures or more robust policy strategies. It would be worth CDC's time to initiate a conversation. Much has been said about the need for a multidisciplinary/transdisciplinary collaboration. He thinks they also need to embark on an international collaboration for key public health issues.

**Dr. Bonomi** emphasized that examining what other countries are doing that already have created good models has been a consistent theme across scientific meetings. Some of the efforts Dr. Liller described with regard to capturing implementation information and journey mapping will be important to inform the work of the CDC.

**Dr. Greenspan** indicated that the CDC is a member of the WHO Collaborating Centres (WHOCC), so they do meet with partner and sister organizations on a regular basis and discuss some of these issues that fall under their purview. She agreed that more could be done with and learned from partners abroad.

**Dr. Clemens** added that this could fit well under some of the existing proposed research questions under the proposed priorities, such as looking at the most effective ways to increase adoption of interventions or examples of analytic techniques among countries that have a better handle on their drowning problems and have had more success in reducing drowning as a leading COD among children. She thought it would be good to spell this out better within some of the proposed research questions.

In addition to the important issue of health equity and the framing around cultural issues, **Dr. Rich** pointed out that perhaps a more effective way of framing this may be through a structural racism perspective. What appears to be cultural, such as why people cannot swim, really are the result of long-term structural perspectives. Including this in the research questions may open up other areas. Some of this is about internalized oppression due to lack of access to safe places to engage safely in learning how to swim. He noticed that framing was absent in the *MMWR* publication.

**Dr. Greenspan** stressed that because this is an emerging area, NCIPC is in a learning mode for this domain and expressed appreciation for the BSC's input. She noted that the Injury Center had done this work many years ago, but probably dropped it as a priority due to resource issues. They do recognize the importance of health equity and the importance of addressing this domain in terms of youth and babies.

## Public Comment Session

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

**Mr. Cabada** thanked everyone for their participation in the BSC meeting and indicated that all public comments would be included in the official record and would be posted on the CDC website with the official meeting minutes at CDC.gov/injury/bsc/meetings.html. He also indicated that while they would not address questions during this public comment period, all questions posed by members of the public would be considered by the BSC and CDC in the same manner as all other comments. He invited those who did not have an opportunity to speak in person to submit their comments in writing to ncipcbsc@cdc.gov. No public comments were provided during this open session.

## Closing Comments / Adjournment

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

**Dr. Greenspan** recognized all of the members who had reached the end of their terms and would be rotating off of the BSC. She acknowledged and thanked Drs. Floyd, Franklin, Kaplan, Liller, and Lumba-Brown for their valuable service to the CDC, NCIPC, and HHS. The success of the BSC depends upon individuals like them who dedicate their valuable time to providing advice on the quality and direction of NCIPC science. The past few years have been especially important in NCIPC's interactions with the BSC in NCIPC's work in terms of updating the Opioid Guideline, firearms research, and the greater focus on reducing inequities in public health. The

BSC members' work in the secondary review process also is crucial in terms of helping NCIPC identify the most important research to fund and in keeping attention focused on what the Injury Center can do to improve the extramural review process, the way in which Notices of Funding Opportunity (NOFOs) are framed, and in terms of outreach to try to involve a broader pool of academic researchers. There are plans to further discuss the extramural review process during the Fall BSC meeting. Dr. Greenspan invited those rotating off before then to submit comments to her that could be used in the discussions during the Fall meeting. She emphasized that NCIPC would appreciate members who were rotating off of the BSC remaining involved with the Injury Center on other efforts, such as serving as reviewers on primary peer reviews.

**Amy Bonomi, PhD, MPH**
**Chair, NCIPC BSC**
**Founder, Social Justice Associates**
**Affiliate, Harborview Injury Prevention Research Center**
**University of Washington**

**Dr. Bonomi** thanked CAPT Jones, Ms. West, and Dr. Clemens for providing an overview of research priorities and for being open to the feedback from BSC members and Dr. Greenspan for probing the BSC with additional questions for consideration. She expressed gratitude to the BSC for their contributions and offered sincere appreciation for the efforts of those rotating off of the committee. She reminded all BSC and *Ex Officios* members to send an email to Mrs. Tonia Lindley stating that they participated in this meeting.

With no announcements made, further business raised, or questions/comments posed, **Dr. Bonomi** officially adjourned the Forty-First meeting of the NCIPC BSC at 1:05 PM.

## Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the August 23, 2022 NCIPC BSC meeting are accurate and complete:

**Date**

**Amy Bonomi, PhD, MPH**
**Co-Chair, NCIPC BSC**

## Attachment A: BSC Meeting Attendance

### NCIPC BSC Chair

Dr. Amy Bonomi, PhD, MPH
Chair, NCIPC BSC
Founder, Social Justice Associates
Affiliate, Harborview Injury Prevention & Research Center
University of Washington

### NCIPC BSC Executive Secretary

Arlene Greenspan, DrPH, MPH
Associate Director for Science
National Center for Injury Prevention and Control
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Founding Director, Center for Community Resilience

Frank Daniel Floyd MD, FACP
Medical Director
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Department of Social Welfare
Luskin School of Public Affairs

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Angela Lumba-Brown, MD
Clinical Associate Professor, Emergency Medicine and Pediatrics
Co-Director, Stanford Brain Performance Center, Director of Research

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Elizabeth Miller, MD, PhD
Professor and Chief
Children's Hospital of Pittsburgh
University of Pittsburgh Medical Center

Steve Ondersma, PhD
Clinical Psychologist and Professor
Division of Public Health and Department of Obstetrics, Gynecology, and Reproductive Biology
Michigan State University

Rosalie Pacula, PhD
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Price School of Public Policy
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John A. Rich, MD
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Director, Center for Nonviolence and Social Justice
Rich Drexel University

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Administration for Children and Families

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Surveillance and Field Investigations Branch
Division of Safety Research
National Institute of Occupational Safety and Health

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Science Policy and Evaluation Branch
Office of Science Policy, Planning, and Communications
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## Attachment B: Acronyms Used in this Document

| Acronym | Expansion |
|---|---|
| AAP | American Academy of Pediatrics |
| ADID | Alcohol- and Drug-Impaired Driving |
| ADS | Associate Director for Science |
| AI/AN | American Indian/Alaskan Native |
| BSC | Board of Scientific Counselors |
| CCTI | Cambridge Communications and Training Institute |
| CDC | Centers for Disease Control and Prevention |
| COD | Cause of Death |
| COI | Conflict of Interest |
| DEBIA | Diversity, Equity, Belonging, Inclusion, and Accessibility |
| DFO | Designated Federal Official |
| DIP | Division of Injury Prevention |
| DOT | Department of Transportation |
| DUIP | Division of Unintentional Injury Prevention |
| DVP | Division of Violence Prevention |
| ET | Eastern Time |
| EU | European Union |
| FACA | Federal Advisory Committee Act |
| FARS | Fatality Analysis Reporting System |
| FIA Foundation | Fédération Internationale de l'Automobile Foundation |
| FPRC | Florida Prevention Research Center |
| FY | Fiscal Year |
| HHS | (Department) Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act |
| IIHS | Insurance Institute for Highway Safety |
| JHU | Johns Hopkins University |
| *JSR* | *Journal of Safety Research* |
| ML | Machine Learning |
| *MMWR* | *Morbidity and Mortality Weekly Report* |
| MV | Motor Vehicle |
| MVIP | Motor Vehicle Injury Prevention |
| NCCDPHP | National Center for Chronic Disease Prevention and Health Promotion |
| NCCDPHP | National Center for Chronic Disease Prevention and Health Promotion |
| NCEH | National Center for Environmental Health |
| NCEZID | National Center for Emerging Zoonotic and Infectious Disease |
| NCIPC / Injury Center | National Center for Injury Prevention and Control |
| NHTSA | National Highway Traffic Safety Administration |
| NIAAA | National Institute on Alcohol Abuse and Alcoholism |
| NOFO | Notice of Funding Opportunity |
| NSC | National Safety Council |
| NTSB | National Transportation Safety Board |
| OPP | On Par Production |
| SDOH | Social Determinants of Health |
| SME | Subject Matter Expert |
| SS4A | Safe Streets and Roads for All |

| Acronym | Expansion |
|---|---|
| TA | Technical Assistance |
| TRB | Transportation Research Board |
| US | United States |
| WHO | World Health Organization |
| WHOCC | WHO Collaborating Centres |

# Board of Scientific Counselors, NCIPC
# Closed Session
# August 23, 2022

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

# Contents

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

Forty-First Meeting
August 23, 2022

Virtual / Teleconference Meeting
Closed to the Public

## Summary Proceedings

The Forty-First meeting of the Board of Scientific Counselors (BSC) National Center for Injury Prevention and Control (NCIPC; Injury Center) was convened on Tuesday, August 23, 2022 via teleconference and Zoom. The BSC met in closed session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). Dr. Amy Bonomi served as Chair.

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

1. **RFA-CE-22-009:** Rigorous Evaluation of Community-Level Substance Use and Overdose Prevention Frameworks that Incorporate Adverse Childhood Experiences (ACEs)-Related Prevention Strategies. The SEP to conduct primary peer review of the applications to this NOFO was convened as a virtual meeting via Zoom on April 26, 2022.

2. **RFA-CE-22-010:** Rigorous Evaluation of Strategies to Prevent Overdose through Linking People with Illicit Substance use Disorders (SUDs) to Recovery Support Services. The SEP to conduct primary peer review of the applications to this NOFO was convened as a virtual meeting via Zoom on June 14-15, 2022.

3. **RFA-CE-22-011:** Understanding Polydrug Use Risk and Protective Factors, Patterns, and Trajectories to Prevent Drug Overdose. The SEP to conduct primary peer review of the applications to this NOFO was convened as a virtual meeting via Zoom on May 3-4, 2022.

4. **RFA-CE-22-013:** Rigorous Evaluation of Community-Centered Approaches for the Prevention of Community Violence. The SEP to conduct primary peer review of the applications to this NOFO was convened as a virtual meeting via Zoom on n June 28, 2022.

## Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the August 23, 2022 BSC NCIPC meeting are accurate and complete:

| | |
|---|---|
| **Date** | **Amy Bonomi, PhD, MPH**<br>**Co-Chair, BSC NCIPC** |

# Attachment A: BSC Member/Ex Officio Attendance

## Co-Chairs

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Affiliate, Harborview Injury Prevention &
Research Center, University of Washington

Arlene Greenspan, DrPH, MPH
NCIPC BSC Designated Federal Office
Associate Director for Science
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Wendy Ellis DrPH, MPH
Assistant Professor, Global Health
The George Washington University
Founding Director, Center for Community Resilience

Frank Daniel Floyd MD, FACP
Medical Director
United Health Services Medical Group

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Principal Epidemiologist and Director
Community Epidemiology Services
Multnomah County Health Department

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Mayo Clinic College of Medicine and Science

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Luskin School of Public Affairs

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University of South Florida College of Public Health

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Co-Director, Stanford Brain Performance Center, Director of Research

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Professor and Chief
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University of Pittsburgh Medical Center

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National Institutes of Health
Eunice Kennedy Shiver National Institute of Child Health and Human Development

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Constantinos Miskis, JD
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Judy Staffa, PhD, RPh

Associate Director for Public Health Initiatives
Center for Drug Evaluation and Research
Office of Surveillance & Epidemiology
Food and Drug Administration

## Attachment B: Acronyms Used in this Document

| Acronym | Expansion |
|---|---|
| ABU | Approved But Unfunded |
| ACEs | Adverse Childhood Experiences |
| ADS | Associate Director for Science |
| BSC | Board of Scientific Counselors |
| BSC/SRC | Board of Scientific Counselors/Secondary Review Committee |
| CCTI | Cambridge Communications and Training Institute |
| CDC | Centers for Disease Control and Prevention |
| CITS | Comparative Interrupted Time Series |
| COD | Cause of Death |
| COI | Conflict of Interest |
| CV | Cure Violence |
| DID | Difference-in-Differences |
| DIP | Division of Injury Prevention |
| DMP | Data Management Plan |
| DOP | Division of Overdose Prevention |
| DSA | Data Sharing Agreement |
| DVP | Division of Violence Prevention |
| ED | Emergency Department |
| EPICC | Engaging Patients in Care Coordination |
| ERPO | Extramural Research Program Office |
| ESI | Early-Stage Investigator |
| ET | Eastern Time |
| FAs | Family Advocates |
| FACA | Federal Advisory Committee Act |
| FY | Fiscal Year |
| HHS | (Department) Health and Human Services |
| IRB | Institutional Review Board |
| LOS | Letter of Support |
| ME | Medical Examiner |
| ML | Machine Learning |
| MOU | Memorandum of Understanding |
| MSI | Minority-Serving Institution |
| NCIPC; Injury Center | National Center for Injury Prevention and Control |
| NIH | National Institutes of Health |
| NOFO | Notice of Funding Opportunity |
| OGS | Office of Grants Services |
| OUD | Opioid Use Disorder |
| PDMP | Prescription Drug Monitoring Program |
| PI | Principal Investigator |
| PPR | Program Priorities Report |
| PRC | Peer Recovery Coaches |
| PSM | Propensity Score Matching |
| RCT | Randomized Controlled Trial |
| RPDD | Regression Point Displacement Design |
| RTI | Research Triangle Institute |

| Acronym | Expansion |
|---|---|
| SEM | Social Ecological Model |
| SFP | Strengthening Families Program |
| SEP | Special Emphasis Panel |
| SPO | Scientific Program Official |
| SRC | Secondary Review Committee |
| SRO | Scientific Program Official |
| SUDs | Substance Use Disorders |
| SUDORS | State Unintentional Drug Overdose Reporting System |
| SWT | Stepped-Wedge Trial |