U.S. Department of Health and Human Services
National Institutes of Health
61st Meeting of the National Advisory Council on Minority Health and Health Disparities (NACHMD)

Virtual Meeting
https://Videocast.nih.gov/watch=48924

February 7, 2023
11:00 a.m. EST - Adjournment

Meeting Minutes

Council Members Present
Eliseo J. Pérez-Stable, M.D., Chairperson; Director, NIMHD
Emma Aguila, Ph.D., University of Southern California
Lisa L. Barnes, Ph.D., Rush University Medical Center
Neil S. Calman, M.D., Icahn School of Medicine at Mount Sinai
Amy J. Elliott, Ph.D., University of South Dakota School of Medicine
Kimberly S. Johnson, M.D., Duke University School of Medicine
Kenneth A. Resnicow, Ph.D., University of Michigan
Mario Sims, Ph.D., University of Mississippi Medical Center
William M. Southerland, Ph.D., Howard University
Chau Trinh-Shevrin, Dr.PH, New York University School of Medicine

Council Members Absent
Esteban G. Burchard, M.D., MPH, University of California at San Francisco

Ex Officio Members Present
Christine M. Hunter, Ph.D., Office of Behavioral & Social Sciences Research, NIH
Judith A. Long, M.D., VA Center for Health Equity Research and Promotion

Representatives Present
Monica Webb Hooper, Ph.D., Deputy Director, NIMHD
Rina Das, Ph.D., Division Director, Integrated Biological and Behavioral Scientists Administrator, NIMHD
Nathan Stinson, Ph.D., M.D., MPH, Director, Division of Community Health and Population Science, NIMHD

Executive Secretary
Paul Cotton, Ph.D., RDN, Office of Extramural Research Activities, NIMHD

Presenters
Larissa Aviles-Santa, M.D., MPH, Division of Clinical and Health Services Research, NIH

Rena D'Souza, D.D.S, Ph.D., M.S., Director, National Institute of Dental and Craniofacial Research, NIH
LCDR Michael Banyas, USPH, MPA, SBA/STTR Program Manager, NIMHD
Crystal Barksdale, Ph.D., MPH, Program Director, Division of Community Health and Population Sciences, NIMHD
Deborah E. Linares, Ph.D., Health Scientist Administrator, NIMHD
Priscah Mujuru, Dr.PH, R.N., Program Officer, Division of Community Health and Population Science, NIMHD
Yewande A. Oladeinde, Ph.D., M.D., MPH, Director, Division of Community Health and Population Science, NIMHD

Call to Order and Welcome

Dr. Pérez-Stable called the open session to order at 11:00 a.m.

Roll Call, Minutes Review

Dr. Cotton called the roll. Council members and others present introduced themselves. The council unanimously approved the minutes of its September 2022 meeting. Members were reminded of the council meeting dates for 2023-24, that NIH policy allowed them no more than one absence per calendar year, and that they were prohibited from serving on NIH peer review panels while on the council.

NIMHD Director's Report and Discussion

Dr. Pérez-Stable provided a report on NIH and NIMHD-related activities since the September 2022 council meeting.

- Joni L. Rutter, Ph.D., was selected as the Director of the National Center for Advancing Translational Sciences (NCATS) on November 6, 2022, after serving as Acting Director.
- Renee Wegrzyn, Ph.D., is the first Director of the Advanced Research Projects Agency for Health (ARPA-H).
- Nina F. Schor, M.D., Ph.D., has been selected as the permanent Deputy Director for Intramural Research after serving in an Acting role since August 1, 2022.
- Hugh Auchincloss, M.D., assumed the role of Acting Director of the National Institute of Allergy and Infectious Diseases (NIAID) on January 1, 2023.
- In addition to Tony Fauci, M.D.'s departure, other NIH Leadership retirements included Andrea Norris, MBA, NIH Chief Information Officer and Director of the Center for Information Technology; John I. Gallin, M.D., NIH Associate Director for Clinical Research and Chief Scientific Officer of the NIH Clinical Center; and Roger I. Glass, M.D., Ph.D., Director of the Fogarty International Center (FIC) and NIH Associate Director for International Research. Peter Kilmarx, M.D., was named Acting Director of FIC.

- The FY23 Omnibus spending bill was signed into law on December 29, 2022. NIMHD appropriations have steadily grown from $303.2 million in FY18 to $524.4 million in FY23. NIMHD's FY23 discretionary support for health disparities research was $25 million, and they also received an additional $11 million for the Centers for Multiple Chronic Disease Research Centers (MCDRC), as well as a slight increase for Research Centers in Minority Institutions (RCMI).
- 45% of NIMHD's funding distribution goes to research project grants, 19% to Research Centers in Minority Institutions (RCMI), and 12% to the multiple chronic disease research centers (MCDRC), Environmental Disparities Centers, and the Centers of Excellence. NIMHD's intramural program remains at about 3% of the budget, proportionally the lowest of any NIH IC.
- 100% of the FY22 R01 applications received by NIMHD that had a priority score under 20 were awarded. NIMHD has nearly doubled the total number of R01 applications they received in FY22 compared to FY18, and the award success rate has improved dramatically. Dr. Pérez-Stable's goal is to get NIMHD's R01 success rate over 20% and sustain that.
- NIMHD is proud of their ability to fund more K awards and should be able to fund most if not all K applications scored under an Impact Score of 35.
- Other FY22 funding accomplishments include: more than 80 loan repayment awards; $46 million to fund 11 Centers for multiple chronic diseases associated with health disparities plus a Coordinating Center; substantial funds to the Community Engagement Alliance (CEAL) by making an award to the Other Transfer Authority that supports 21 CEAL teams; 11 R01s through the Community Level Interventions RFA; a 75% increase in Career Development Awards; four new Clinical Research Networks for Health Equity to RCMI institutions; and total of $5 million for the RCMI Research Coordinating Network.
- Dr. Pérez-Stable and others briefed the office staff of Representative Josh Harder (D-CA) on the NIH Climate Change and Health Initiative and climate health research efforts.
- Dr. Pérez-Stable and Dr. Monica Webb Hooper briefed the office staff of Senator Ben Cardin (D-MD) on major NIMHD research highlights over the past two years, updates on the NIH Minority Health and Health Disparities Strategic Plan, and collaborative initiatives on health disparities research.
- The Rapid Acceleration of Diagnostics for Underserved Populations (RADx-UP) is now three years out from appropriations. RADx-UP published a special supplement to the *American Journal of Public Health*, which included 19 articles about community-based COVID-19 testing and research in underserved populations and several commentaries by NIH staff and leaders.
- Dr. Pérez-Stable and Dr. Gary Gibbons, Director of NHLBI, attended a CEAL workshop at the American Public Health Association 2022 Annual Meeting in Boston, MA along with CEAL leadership and several PIs. There were 27 presentations on CEAL and an APHA television interview with Drs. Pérez-Stable and Gibbons.
- NIMHD is part of the IMPROVE Initiative led by the National Institute for Child Health and Human Development to address maternal morbidity and mortality. NIMHD's involvement includes funding several R01s. NIMHD could have more impact in the preconceptual and postpartum health areas. The day of the workshop NIMHD coordinated was focused on access

to postpartum care. Dr. Pérez-Stable strongly believes there is a role here for a generalist clinician to see patients after delivery and coordinate working with specialists.

- The PhenX Toolkit's social determinants of health collection has completed phase two, adding 15 new protocols in December 2022.
- As of February 6, 2022, NIMHD has been accepting applications for the Health Disparities Research Institute for 2023. HDRI aims to support the research career development of promising early stage investigators interested in minority health/health disparities research. Applications are due by March 13, 2023. The 2023 HDRI will be held in person on the NIH campus
- NIMHD in collaboration with the National Institute of Nursing Research has led the development of the Science Collaborative for Health Disparities and Artificial Intelligence Bias Reduction platform designed to accelerate research in health disparities, health care outcomes, and artificial intelligence bias mitigation strategies.
- The NIMHD Director's Seminar Series Black History Month Presentation will be by Dr. Consuelo Wilkins of Vanderbilt University Medical Center on Thursday, February 9, from 2-3:30 pm. The topic of the presentation is "The Intractability of Health Disparities: Where Do We Go From Here?"
- NIMHD continues its recruiting efforts and NACMHD members were asked to pass along any qualified candidates.

Dr. Pérez-Stable summarized selected Science Advances since the September 2022 council meeting. Most of these studies were funded by NIMHD and all are published.

- A study in New York City found that expanding eligibility for the Earned Income Tax Credit to adults without dependent children during the pandemic resulted in a 1.9% increase in employment, 6% increase in after-bonus earnings, and a decrease in psychological distress for women and noncustodial parents. There has been other evidence to support these kinds of interventions, but this was one of the things the U.S. did right during the pandemic. How we learn lessons from this going forward will be important.
- An NIAID-funded grant (from an initiative led by NIMHD) focused on the effect of COVID-19 vaccine messaging platforms in emergency departments on vaccine uptake found that among intervention participants there was greater vaccine acceptance after .5-6 hours and greater vaccine uptake within 30 days of emergency department visit. The effect size was larger for Latinos and those who did not have a primary care physician.
- The REGARDS study was designed to look at strokes and stroke morbidity and mortality and has shown that the same level of systolic blood pressure for African American adults doubles the risk of a cerebrovascular event compared to White counterparts over time. It is a large study of 23,901 coronary heart disease-free participants, following them over 11 years. High LDL cholesterol showed an increased risk for all participants; low HDL showed an increased hazard ratio of 1.22 for White adults and no significant increase for Black adults; and high HDL showed no decreased risk for all participants. It is unclear what this means, but it may be that low HDL cholesterol may not be as bad as previously thought for African American populations and not as protective as previously thought.

- Sociodemographic and mortality data from 3,110 U.S. counties for 2015-2019 was used to assess residential racial and economic segregation measured via the Index of Concentration at the Extremes (ICE). The least privileged ICE quintile demonstrated a mean age-adjusted all-cancer mortality rate of 179.8 per 100,000 compared to a rate of 146.1 per 100,000 for the most privileged quintile, with a clear-cut gradient between each quintile of wealth.
- An NIMHD grant-funded, culturally adapted, computerized intervention to improve the health literacy for older Latino persons with diabetes underwent a proof of concept with 25 patients and five clinical pharmacists. These kinds of computerized health literacy interventions can be tailored to patients' needs to allow precision counseling during medication management, and may optimize adherence.
- A randomized controlled trial of 277 participants over 50 years of age compared the short-term behavioral activation to treatment delivered by clinicians through telemedicine and a control group that was only attention or telephone support. Both tele-behavioral interventions were more cost-effective, with incremental cost-effectiveness ratios well below $50,000 per year of quality of life added. Lay counselors may have the potential to fill the shortage in the geriatric mental health workforce.
- An analysis of the Health and Retirement Study, which evaluated what happened to people who were employed at the start of the pandemic and over that first year, found that Black and Latino adults had a higher likelihood of job loss regardless of education. Men that were Black, Latino, or other racial category were more than 90% less likely to transition to remote work compared with White men. Those who experienced job loss with decreased income reported poorer well-being overall including greater financial hardship, food insecurity, and poor/fair self-rated health.
- An NIMHD-funded study assessed self-reported COVID-19 death exposure based on race and ethnicity and other sociodemographic factors among U.S. adults. Of the 2,022 participants surveyed, the likelihood of losing a close friend or family member due to COVID-19 was greater for those over 60 years of age, those from racial/ethnic minority groups, married/coupled respondents, those who had foregone care due to cost in the past year, and those who reported a COVID-19 infection. Differential exposures to COVID-19 deaths reflect the virus' disproportionate impact in the U.S. and may exacerbate health disparities over time.
- The AIDS Project Los Angeles Health recruited 304 Black adults with HIV and examined the associations of medical mistrust with perceived discrimination, poor antiretroviral therapy (ART) adherence, and lower care engagement among the participants. The study found significant effects of perceived discrimination on ART adherence, and care engagement through medical mistrust was observed.
- 187 low-income, early postpartum Latinas in Los Angeles completed the Perceived Immigration Policy Effects Scale questionnaire between September 2018 and November 2021. Compared to the pre-pandemic participants, the early pandemic participants had higher rates of perceived vulnerability to immigration policies, perceived discrimination, isolation, and family threats. Higher perceived immigration policy vulnerability during the early period of COVID-19 suggests greater social inequities among U.S. Latinas during the pandemic.

- The Jackson Heart Study examined the associations between religiosity/spirituality and the American Heart Association's Life's Simple 7 (LS7) metrics among 2,987 participants. The study found religious attendance was associated with increased likelihood of achieving intermediate/ideal levels of physical activity, diet, smoking cessation, blood pressure, and the American Heart Association's Life's Simple 7 scores (LS7). Religious coping is associated with increased odds of achieving intermediate/ideal levels of physical activity, diet, and smoking cessation. Higher levels of religiosity/spirituality were associated with intermediate/ideal cardiovascular health (CVH) across multiple LS7 indicators. Reinforcement of religiosity/spirituality in lifestyle interventions may help reduce CVH risk and disparities in this group.
- The Health and Retirement Study assessed the influence of cognitive function and type 2 diabetes on mortality in Latino populations. The study found that neighborhood factors explained 11% of variance in the rate of cognitive decline, and cognitive impairment was linked to higher mortality, particularly in those without dementia. Living in an ethnic enclave was related to slower rates of cognitive decline, and living in areas of economic disadvantage was related to a faster decline.
- The Case Western Reserve University Center of Excellence studied community members as reviewers of medical journal manuscripts. The three year trial trained participants and had them review 578 original research manuscripts submitted to medical journals. The editors generally rated the reviews well, with little difference compared to scientific reviews. Community member reviews identified different viewpoints regarding the diversity of study participants, relevance to patients and communities, cultural considerations and social context, and implementation of research by patients and communities.
- Age-standardized diabetes mortality rates per 100,000 people were unchanged in rural counties in 2017-2018 compared to 1999-2000, but rates were significantly lower in medium-small and metro counties. Of all regions and urbanization levels, the mortality rate in 2017-2018 versus 1999-2000 was higher only in the rural South.
- A Medicaid study looking at the influence of social determinants of health on future healthcare costs found that future morbidity burden was significantly higher in the upper two social risk classes compared to the lowest class. Future healthcare spending increased from the lowest social risk category ($14,906) to the highest ($36,961). When current morbidity is included in cost prediction models, social determinants of health were not significant predictors of costs. The impact of social determinants of health on future expenditures is largely accounted for by concurrent morbidity.
- From NIMHD's intramural program, a paper in *Nicotine and Tobacco Research* evaluated trends in education-related smoking disparities among U.S. Black and White adults. These disparities increased over time, especially among Black males and females, followed by White female adults. There were small or no reductions in smoking among those with less than a high school education. These tobacco-use patterns were worse in the Midwest and South.
- Data on 4,705 Black persons enrolled in the Jackson Heart Study showed higher perceived neighborhood violence and problems were associated with shorter sleep duration. Higher social

cohesion as related to longer sleep duration and was mediated through higher total physical activity. Future interventions may aim to increase sleep duration through community-focused efforts to promote physical activity, create cohesive communities, and reduce neighborhood social stressors.

- A study of the impact of COVID-19 policies on trauma hospitalization in North Carolina found that these policies impacted non-COVID health care utilization and may have worsened healthcare disparities. Assault hospitalizations increased after the stay-at-home orders among Black individuals and 18-44-year-old males. These rates were still elevated after the restrictions were lifted.
- NIH published an article in the policy forum section of *Science* outlining their COVID-19 research response to develop vaccines, therapeutics, diagnostics, and community engaged initiatives.

Presentations

Oral Health for All: Realizing the Promise of Science, Rena D'Souza, DDS, Ph.D., M.S., Director, National Institute of Dental and Craniofacial Research (NIDCR), National Institutes of Health
https://Videocast.nih.gov/watch=48924&start=5500

Dr. D'Souza presented an overview of NIDCR's work to shape the future through dental career development, UNITE and other programs that acknowledge patient social and emotional factors. She also commented how NIDCR leverages NIH-wide resources and acknowledges that they cannot advance their science without representing the demographics of the U.S. Dr. D'Souza asked that if any of the NACMHD members knew of someone interested in dentistry or oral health research topics, to encourage them to get in touch with her and she can find them the right spot in their intramural or extramural program. NIDCR has taken the NIH UNITE Initiative to the Institute level with a racial and ethnic equity plan and created a cultural connector to create a sense of belonging across the NIDCR workforce. To look at populations at risk for poor oral, health scientists must recognize that fear and anxiety may play a role in deterring people from seeking dental care, particularly with African American women and Latino children. She also noted that NIDCR will be celebrating its 75th anniversary with a focus on science and generating/nurturing that pipeline for the future. They will be having a variety of events, including one to honor their trainees across the country.

Ken Resnicow asked what Dr. D'Souza saw as the role of dentists and dental assistants in health promotion and smoking cessation. He also asked how much she felt the racial and ethnic disparities she identified on the patient level is due to the low representation of underrepresented dentists of color, leading to very few concordant patient-provider interactions. Dr. D'Souza said it is hard to dissect the second question because they do not have the evidence or datasets to show one way or the other, but it is hard to imagine they are not linked. Student debt for dentists is a big hurdle, and they are trying to approach this by getting help from industry partners and stakeholders groups to make scholarships and loan repayment available. On the first question, there is a huge role for the expanded team of oral health professionals; getting there will take some clever strategic thinking. The involvement of mid-level nurse practitioners varies by state, but it is especially helpful in rural areas.

Duke Center for REsearch to AdvanCe Healthcare Equity: REACHing for Diversity in the Research Workforce and Equity in the Clinical Encounter, Kimberly Johnson, M.D., Professor of Medicine, Division of Geriatrics, Duke University School of Medicine
https://Videocast.nih.gov/watch=48924&start=8760

Dr. Johnson discussed her background and her work over the last six years leading Duke's Center of Excellence program's efforts to increase research workforce diversity with an emphasis on increasing research among underrepresented racial and ethnic groups. Racial and ethnic disparities lead to excess deaths and are costly to the economy, with one estimate putting their cost to the nation at about $135 billion a year. Disparities exist throughout the life course, beginning in pregnancy and going until the end of life, and we can find them in almost any diagnosis or disorder. More recently, there has been increased interest in the social and structural determinants that lead to disparities and in-service drivers of health. Dr. Johnson has been particularly focused on clinical care and centered most of her comments on that area. Issues of access play a major role in contributing to health disparities. Biased stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in healthcare. The vast majority of studies have focused on patients. Duke was interested in how they might impact providers and care teams in the clinical encounter to address some of these disparities. The theme of REACH Equity is developing and testing interventions that reduce racial and ethnic disparities in health by improving the quality of patient-centered care in the clinical encounter. The work they do on this theme is disease-agnostic and broadly applicable.

Dr. Johnson provided an overview of her Center's aims, focusing her remarks on the goal of developing investigators at all stages with a particular focus on those from racial/ethnic groups that have been underrepresented in medicine and science. REACH Equity has helped to create an umbrella for the integration of transdisciplinary health disparities research that extends across the campus. The program funds 63 investigators, 58% of whom are from underrepresented racial/ethnic groups. The Center funds three Disparities Research Scholars to conduct pilot projects related to the REACH Equity theme, $50,000 for a one-year award from the Centers of Excellence grant supplemented with additional funding to make it a two-year award of $75,000/year for two years. With this, they have been able to fund 18 scholars. In addition to the work they have done, they have also been engaged in other opportunities to facilitate culture change across the institution.

Dr. Johnson discussed two of the Center's research projects: (1) The effect of a clinician communication coaching intervention on the quality of communication in cardiology clinical encounters and (2) improving unmet palliative care needs among ICU family members with a needs-targeted app intervention. The first project aimed to determine the effect of a clinician coaching intervention and of the intervention versus control on racial disparities, on objective measures of the quality of communication, and patients' perceptions of the quality of patient-centered care. The study of communication behaviors found no difference in the providers' use of reflective statements or open-ended questions or in the global ratings between the intervention and control groups (with the exception of better flow from intervention). Empathic statements and providers asking "what questions

do you have?" were more common in the intervention group. The analysis of race by intervention interaction was not significant, indicating that there was no variation in the effectiveness of the intervention by race. Pre-intervention measures showed differences in tone and ratings for flow, concern, and attentiveness, with the mean higher for White patients than Black patients (indicating the tone was more favorable to White versus Black patients). The intervention led to higher results in reflective statements for both groups and increased the use of "what questions do you have?" more for Black patients than White patients. The intervention also eliminated the differences between groups regarding flow, concern, and attentiveness. The second research project sought to determine the effect of the ICUconnect app intervention versus usual care on unmet needs of caregivers of ICU patients over the course of a week post-intervention and to determine the effectiveness of the app between racial groups. The study showed that ICUconnect substantially reduced unmet needs that persisted through the week. For white patients, there was about a 20% drop, which has clinical significance, though there was no difference in effectiveness between intervention and usual care for Black participants. The team is still working to better understand these outcomes. The Centers of Excellence program is an excellent opportunity to support disparities research and to mentor, develop, and support investigators from underrepresented groups. In their work, they have targeted areas of known disparities, and in doing so, may not always reduce disparities or improved care in some domains for minoritized groups. They have been thinking about what additional tailoring may be required for provider interventions that more specifically address bias, stereotyping, and uncertainty.

Lisa Barnes asked what the hopes are of having the study on communication issues help with the medical curriculum. She also asked about the "leaky pipeline" in regards to diversifying the workforce. They have been able to get people in, but too often they do not advance to the stages where they are really making impacts. Dr. Johnson said they get a lot of requests about medical student teaching. There have been many efforts at various institutions on teaching around issues of diversity, equity, and inclusion, and even racism in medicine. They have discussed the extent to which they could be more effective but do not have plans to do anything yet. In their work with career development awardees, they see people drop out for a number of reasons - the work is hard, and there are many competing demands. Longitudinal mentorship has helped, so that even as people leave the program and move on, they continue to have annual individual scholar meetings to address additional obstacles that come up. There have been concerns that as people move from the earliest stages, there are fewer programs in place to support them if they choose to continue.

Approval of Concepts

Advancing Health Care for Older Adults from Populations that Experience Health Disparities
Presenter: Dr. Yewande A. Oladeinde

The objective of this initiative is to support innovative research designed to advance the science and implementation of diagnostic care guidelines, shared decision making to enhance care planning and patient agency, and effective strategies for coordinating care for older adults from populations that

experience health disparities. This initiative will support interventions, clinical trials, mixed methods, simulations modeling, quasi-experimental studies, and quality improvement studies.

Dr. Johnson said this is an important issue as the nation has an aging population that is increasing in diversity. She suggested emphasizing studies that are at the intersection of racism and ageism. Given the recent emphasis on social and structural factors, the concept should really highlight interest in impact and interventions to address those factors. She encouraged consideration of whether they are interested in studies that focus on and enroll caregivers and intervene on them in a way that impacts the health of their care recipients. For the focus on protective factors and resilience, it might be a good idea to call out the degree to which some of the services, like age-friendly health systems or other quality improvement initiatives, affect disparities. For the issue of patient autonomy, it is important to think about variation across cultures and maybe focus on honoring preferences for decision making.

Neil Calman raised two issues that are important from the clinical perspective. One is looking at where people get their primary care, because that can make a huge difference. The second is that the Medicare plans, especially Medicare Advantage, which pays for a lot of the care described in the concept, is undergoing many changes.

Dr. Johnson made a motion to support moving the concept forward for funding opportunity announcement (FOA) development. Dr. Calman seconded the motion. The council passed the motion unanimously.

Mechanisms and Interventions to Address HIV-Related Comorbidities in Populations Who Experience Health Disparities
Presenter: Dr. Deborah Linares

The objective of this concept is to support research to examine mechanisms and interventions to address HIV-associated comorbidities among populations experiencing health disparities. Examples of conditions include osteoporosis, COPD, chronic kidney disease, and diabetes. Previous funding opportunity on this topic led to five R01s that are still in progress.

Lisa Barnes said this concept would be of great interest to HIV researchers because, while the topic of the "graying of the HIV population" has been at the forefront of HIV research, there remain many unanswered questions regarding the consequences of the virus. She emphasized a few points that should be considered as this concept moves forward: the role of age at which people acquire HIV, the role of treatment history, how HIV treatment interacts with treatment for other comorbidities, and how this is exacerbated in populations facing disparities.

Mario Sims commented that the concept developers should consider having evidence-based programs or services that work in order to know exactly where in the structure interventions should take place or make changes. They should consider a life course approach among this population, as chronic morbidities may develop early in life and exist over time and manifest downstream in this

subpopulation. There should be a consideration of the role neighborhood environments play in contributing to the risk of multimorbidity or its protecting influence.

Dr. Barnes made a motion to support moving the concept forward for FOA development. Dr. Sims seconded the motion. The council passed the motion unanimously.

Housing Instability among People Living with HIV/AIDS; Presenter: Dr. Yewande A. Oladeinde

Homelessness affects nearly 600,000 persons and 1.8% of the US adult population experiences housing instability. The objective of this concept is to support innovative, collaborative, and multidisciplinary research designed to understand the intersections between housing, care seeking, and treatment behaviors of people living with HIV and/or at risk for HIV experiencing housing instability and identify effective strategies for engaging this population in attaining optimal HIV care, medication, adherence, and health outcomes.

William Southerland said this is an important concept, as 69% of new AIDS cases are either Black or Hispanic persons. This concept should provide additional insight into the interconnectedness of all those factors that contribute to disparities in those seeking health care and the ability to adhere and the role of housing instability in that. It is important that this concept go beyond the identification of barriers to care to look at the effectiveness of interventions. Since housing instability is so closely linked to economic status, it would be interesting to explore how much of a proxy economic status would be for some of the same factors mentioned in the concept in terms of housing instability.

Ken Resnicow suggested clarifying in the title of the concept and objectives that this is among populations that experience disparities. He suggested adding to the substance use, diet, smoking, and sex work as other aspects that may interact with these other variables along the intersectionality perspective. He also suggested adding quality of life as another potential targeted outcome. Other intervention ideas they might want to suggest: alternate case management models, care coordination models, and peer-based interventions. It's not clear whether prevention or transmission is incorporated into the concept. They need to be clear in their rationale for where they draw the line on that.

Dr. Southerland made a motion to support moving the concept forward for FOA development. Dr. Resnicow seconded the motion. The council passed the motion unanimously.

Interventions to Address Disparities in Chronic Liver Diseases and Cancer
Presenter: Dr. Olga Herren

The objective of this concept is to support multilevel and multidomain intervention research to reduce disparities in liver diseases and liver cancer among populations experiencing health disparities in the U.S. Hepatitis B vaccine and Hepatitis C treatment were presented as examples.

Chau Trinh-Shevrin said that a grassroots approach is essential in reaching immigrant and limited English proficient communities, many of whom have expressed tremendous stigma from both hepatitis and cancer. She applauded this concept and noted that among the populations identified, there are also barriers related to immigration status, lack of health insurance, and cultural and language barriers that play a role in accessing health care. She encouraged that the concept underscore expertise and the use of methods around implementation and dissemination research. It would be critical to think through how we understand what works across these diverse communities and settings, as well as how we understand and support strategies that impact reach, adoption, and uptake. Non-alcoholic fatty liver disease (NAFLD) is associated not only with increased risk for liver cancer, but also other cancers such as colorectal, esophageal, and gastric cancer. NAFLD prevalence rates are increasing in the U.S.; hence, strategies are needed to reach both types of populations. The concept developers should make sure studies with respect to liver disease also ensure diversity within those populations to support disaggregated data collection. Strategies to target stigma is a critical approach, as it is a fundamental driver for sexual and gender minorities with respect to hepatitis and cancer disparities. The use of community-engaged approaches is critical for reaching marginalized communities. They need to work with trusted community organizations, messengers, and community health workers. System level interventions would be helpful to encourage applications that work in safety net provider systems.

Amy Elliott added that putting more emphasis in the prevention space in rural areas and areas with large American Indian populations would enhance the potential of this concept. Attention on the upstream social determinants of health and how interventions can be leveraged at that stage for the prevention of the disease is a sweet spot for this funding opportunity. It also opens up areas for participation from those in less populous areas that need this work desperately. When thinking about the multisystem level interventions, she suggested specifically thinking about family level interventions.

Dr. Trinh-Shevrin made a motion to support moving the concept forward for FOA development. Dr. Elliott seconded the motion. The council passed the motion unanimously.

Youth Violence Prevention Interventions
Presenter: Dr. Crystal Barksdale

The objective of this concept is to support research to develop and test multilevel youth violence prevention interventions for populations that experience health disparities, including strategies that address structural discrimination and other social determinants of health.

Dr. Neil Calman said he is very supportive of the concept but sorting out how one would prioritize different types of studies will be a very difficult task, given the complexity of the topic. He hoped that any funding that might develop around the prevention of community violence would use community-based participatory research methods that get a broad range of inputs from different sectors of the community. He suggested the major focus be on schools and then looking at all the structures that children encounter, which are well-articulated in the concept.

Dr. William Southerland pointed out that the difference between this concept and another NIMHD concept is the expansion of the age range as well as an increased emphasis on the multilevel and multidomain approach. It provides a chance to really explore synergisms that may be available among existing approaches and see how new interventions can be added to existing ones. The way the two targets of violence and discrimination prevention are laid out should lead to some well-focused proposals that generate increased potential in addressing this difficult problem. He noted that different groups will have their own definitions of "youth" and "young adult," and NIMHD may want to add some clarity on how they are using the terms.

Dr. Calman made a motion to support moving the concept forward for FOA development. Dr. Southerland seconded the motion. The council passed the motion unanimously.

Innovative Health Disparities Research and American Indian/Alaska Native Small Businesses
Presenter: LCDR Michael Banyas, MPA

The objective of this concept is for NIMHD to lead an NIH-wide SBIR/STTR innovative research proposal to develop a product, technology, and/or service for commercialization with the aim of improving American Indian/Alaska Native health.

Dr. Amy Elliott said this funding opportunity could help highlight for American Indian and Alaska Native businesses that they are eligible for participating in this initiative and create innovative health disparities research/products that can help those small businesses. Many of the examples provided under specific areas of interest relate to service type programs, which tend to be personnel heavy. It will be important for applicants and reviewers to really understand how this funding opportunity and their small business proposals will help facilitate/connect and provide clarity within a complex network of service agencies rather than just being another service type entity. Doing American Indian/Alaska Native research in the right way can be very time-intensive, which needs to factor in to this opportunity. Highlighting the need to educate all parties who may be interested or intersect with American Indian/Alaska Native businesses on some level would be helpful in advancing this initiative.

Dr. Emma Aguila said programs promoting social entrepreneurship have been quite successful around the world tackling important challenges. This initiative including a specific group of vulnerable population is very timely. Dr. Aguila suggested adding a component in this initiative that provides access to additional research funds when partnering with a research organization or university to analyze the impact of the intervention and whether it could be replicated on other vulnerable populations or document best practices in a specific area.

Dr. Elliott made a motion to support moving the concept forward for FOA development. Dr. Aguila seconded the motion. The council passed the motion unanimously.

Understanding and Addressing Health Disparities and Access to Health Care Among Rural Populations
Presenter: Dr. Priscah Mujuru, DrPH

The objective of this concept is to address gaps in scientific knowledge and support research that addresses multilevel influences and multiple domains related to health disparities experienced by people who live in rural communities, with "rural" being defined as all non-metro counties.

Dr. Emma Aguila commented on the changing composition of rural populations. Older adults represent a higher share of the population in rural areas than in urban or suburban counties. The rural population has become more racially and ethnically diverse over the past decade. She suggested considering as research priorities climate change/environmental exposures and racial discrimination. Including the introduction of interventions that could improve socioeconomic status and health of rural populations may also prove beneficial.

Dr. Ken Resnicow commented on the change in the breakdown of political affiliation in rural areas. This is reflected in deep social differences in rural and urban America. While recognizing the need to be delicate, Dr. Resnicow encouraged the concept developers to divide the research agenda into two buckets: (1) Access and structural issues; and (2) Psychosocial, including political, personality, and cultural attributes. They should encourage more research about the role of culture/personality and how these impact rural health. This is one of the most poorly understood aspects of health disparities in rural populations. Clarity was needed on whether the concept is encouraging only intervention work or if it also welcomes descriptive work. Subgroups of particular interest that may warrant specific research include farmers and migrant farm workers. He appreciated the inclusion of tobacco and substance use, and they may want to include other mental health issues that differ in rural populations. The concept developers should be very intentional that they are looking at the effect of rurality above SES; they need to be clear how, through their sampling and data analyses, they make sure they are looking at the effect of rurality above simple SES.

Dr. Aguila made a motion to support moving the concept forward for funding opportunity development. Dr. Resnicow seconded the motion. The council passed the motion unanimously.

Working Group to Review the Division of Community Health and Population Science (DCHPS)

Dr. Monica Webb Hooper, Deputy Director, NIMHD, proposed that the NACMHD convene a work group charged with conducting a comprehensive review of DCHPS, examining published funding opportunity announcements, the research portfolio over the past five years, and scholarly products by grantees and the impact these have had. The review will also evaluate alignment with the state of the science and the NIH Minority Health and Health Disparities Strategic Plan (2021-2025). The Working Group will submit a report summarizing the findings of the review, research gaps, and recommendations regarding opportunities to advance the state of the knowledge, interventions, and translation using community health and population science approaches. Working Group membership will include select NACMHD members, as well as individuals with appropriate expertise from the extramural community. The Working Group will report to the NACMHD and advise the NIMHD Director.

Dr. Sims made a motion to approve the functional statement to convene a Working Group. Dr. Barnes seconded the motion. The council passed the motion unanimously.

Closing Remarks and Adjournment

Dr. Pérez-Stable adjourned the meeting at 5:06 p.m.

END NOTE: REVIEW OF GRANT APPLICATIONS_ CLOSED SESSON A portion of the meeting was closed to the public in accordance with the provisions set forth in Sections 552b(c)4 and 552b(c)6, Title 5 U.S.C. and 10(d) of the Federal Advisory Committee Act as amended (5 U.S.C. appendix 2). Dr. Pérez-Stable called the Closed Session to order at 1:00 pm, February 6, 2023. Dr. Cotton led the second level review of grant applications submitted to NIMHD programs. Council Members and Staff were instructed on conflict of interest and confidentiality regulations. Members and Staff absented themselves from the meeting room and discussions for which there was a potential conflict of interest, real or apparent. The Council considered 456 competing applications requesting an estimated $270,829,042 in requested total costs for year 1 for non-fellowship grants. Funding recommendations for all applications submitted in response to funding opportunity announcements were reviewed. Applications submitted in response to program announcements and special program review announcements were considered by the Council through En Bloc voting.

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Eliseo J. Pérez Stable, M.D. Date
Director
National Institute on Minority Health and Health Disparities, NIH

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Paul Cotton, Ph.D. Date
Designated Federal Official
National Institute on Minority Health and Health Disparities, NIH