U.S. Department of Health and Human Services
National Institutes of Health
70th Meeting of the National Advisory Council on Minority Health and Health Disparities (NACMHD)

Virtual Meeting

September 5, 2025
10:00 a.m. EDT - Adjournment

Meeting Minutes

Council Members Present
Monica Webb Hooper, Ph.D., Chairperson; Acting Director, NIMHD
Samuel E. Adunyah, Ph.D., Meharry Medical College
Jose A. Bauermeister, Ph.D., MPH, University of Pennsylvania
Lisa M. Cacari Stone, Ph.D., University of New Mexico
Valarie Blue Bird Jernigan, Dr.PH., MPH, Oklahoma State University
Frank J. Penedo, Ph.D., University of Miami

Council Members Absent
Kendrick E. Curry, Ph.D., M.Div., The Pennsylvania Avenue Baptist Church

Ex Officio Members Present
Crystal Henderson, Department of Veterans Affairs

Representatives Present
Kimberly Allen, Associate Director for Administration, NIMHD
Larissa Aviles-Santa, M.D., MPH, Director, Division of Clinical and Health Services Research, NIMHD
Rina Das, Ph.D., Director, Division of Integrative Biological and Behavioral Sciences, NIMHD
Nathan Stinson Jr., 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
Priscilla Grant, JD, Chief Grants Management Officer, NIMHD

Call to Order and Welcome

Dr. Webb Hooper called the open session to order at 10:00 a.m.

Roll Call and Council Minutes Review

Dr. Cotton called the roll and invited Council members and NIMHD staff to introduce themselves. The Council unanimously approved the minutes of its May 2025 meeting. Dr. Cotton announced future meeting dates of February 5-6, 2026; May 18-19, 2026; and August 10-11, 2026. The February 5-6, 2026 meeting will be held virtually.

NIMHD Acting Director's Report and Discussion
https://videocast.nih.gov/watch=56883&start=580

Dr. Webb Hooper greeted the Council and provided a report on NIH and NIMHD-related activities since the previous meeting.

- On August 22, NIH released a forward-looking plan to promote gold-standard science across the agency, in response to the Executive Order on Restoring Gold Standard Science and Federal Agency Guidance. It incorporates nine interlocking tenets adopted by the U.S. Government and aligns with the Department of Health and Human Services framework. The report outlines key NIH accomplishments and presents a transparent vision for the road ahead.
- On August 15, NIH released a new unified strategy, with an accompanying statement by Dr. Bhattacharya, the NIH Director, to coordinate and align research priorities, funding approaches, and long-term impact across NIH so as to create more coherence across Institutes and Centers, minimizing redundant efforts and ensuring investments are driving meaningful improvement in public health. An essential pillar of the strategy is to balance scientific opportunity with mission-critical objectives. There is a focus on accelerating investment in transformative tools like artificial intelligence, alternative testing platforms, and real-world data sources. NIH is increasing oversight of research funded abroad to better track and ensure it meets the same scientific, ethical, and financial standards as research conducted in the U.S. NIH will also expand support for replication studies to verify and increase confidence in evidence and findings. Funding decisions across NIH will reflect priorities, scientific opportunity, program balance, workforce development, and overall health impact. There is a strong commitment to addressing health disparities using solution-oriented approaches. Individual and external factors that influence health outcomes must be considered and guided by the needs of the research question. Investigators must apply specific, measurable concepts in health disparities and minority health research. NIH will prioritize research focused on actively testing, advancing, scaling, and implementing innovative evidence-based interventions and treatments that improve public health and close gaps. NIH is prioritizing what previous work has referred to as third and fourth

generation disparities research, which focuses on interventions and population-level implementation.

- NIH grant and funding policies and processes will continue to evolve and be refined to reflect current priorities. Online posting of new funding opportunities and notices of policy changes has resumed, and there is a webpage on NIH compliance and policy. Recent updates include:
    - Emphasis on enhancing biosafety, biosecurity, and foreign influence protections in funded research, including revising protocols for international collaboration, pathogen research, and secure data environments.
    - Temporary flexibilities in eligibility for various mechanisms in select programs, including, for example, extensions to early-stage investigator status and, in some cases, delayed timelines for K and R grants.
    - NIH guidelines on the inclusion of women and minorities as clinical research subjects have been updated, strengthened, and made more specific. These guidelines have been given a new title, Inclusion of Women and Members of Racial and/or Ethnic Minority Groups in Clinical Research.
    - New policy requirement to train faculty and researchers identified as senior and key personnel on applications.
- In June the Office of Management and Budget required NIH to use 50% of its remaining competing research project grant (RPG) funds for full-year funded RPGs. Multi-year awards will be funded in full at the start of the project period from a single fiscal year appropriation, rather than subsequent budget years. With this change, NIH anticipates supporting fewer awards and researchers, as well as lower success rates in FY25.
- NIH remains committed to supporting international scientific collaboration when it is in the interests of the U.S., provided the work is conducted in a secure, justifiable, and responsible way. NIH will no longer issue awards to domestic or foreign entities that include a subaward to a foreign entity; finalized implementation of the new award structure is expected by the end of the fiscal year. The goal of the new structure is to provide accountability to the public while continuing to enable important foreign collaborations and to accelerate scientific discovery and improve the lives of all Americans. A short-term solution for active projects has been implemented which allows grant recipients to remove a foreign subaward involving human subjects and renegotiate it as an administrative supplement, to support the health and safety of international research participants and enhance the ability to track financial obligations to foreign entities.
- On August 29th, NIH announced the launch of NIH Highlighted Topics, a resource to inform the research community about scientific areas of special interest to encourage investigator-initiated applications in those areas.
- NIH has a new policy supporting fairness and originality in research. NIH will not consider applications that are either substantially developed by, or contain sections substantially developed by, artificial intelligence to be original ideas. NIH will only accept six new, renewal, submission, or revision applications from an individual PI or multi-PI team for all Council rounds in a calendar year.

- Key points when applying for NIH/NIMHD grants:
    - Be specific about the health problem(s) and/or health disparities.
    - Use unambiguous, scientific descriptors, avoiding jargon where possible.
    - Outcomes and measures should be well-validated, objective, and directly linked to health outcomes.
    - Ensure the funding mechanism is appropriate to the work being undertaken.
    - Researchers are encouraged to apply to NIMHD or parent mechanisms, with a focus on investigator-initiated projects.
    - Specific interest in intervention or observational research with clear, actionable implications.
    - Connect with the program official.
- The PhenX demographics and social determinants of health collection promotes standardization of data and sharing of data and is a great resource for accessing standardizing measures and validated tools.
- Health disparities can be identified based on significantly greater or disproportionate morbidity or premature mortality that's largely preventable on one or more of seven metrics. The health gap should be significant in magnitude, systematically observed across populations, intergenerational, and linked to adverse conditions.
- NIMHD grant selection and funding decisions are based on zones of consideration rather than a strict pay line, providing a more nuanced and context-sensitive approach. This approach promotes flexibility, strategic alignment, and the ability to cover key areas, allowing for consideration of a broader range of meritorious applications, especially those that address critical gaps. Considerations include scientific and technical merit; peer review scores; strong relevance to racial and/or ethnic minority populations, low socioeconomic status (SES), or rural communities, and the combination of those factors with other characteristics that can amplify disparities; recommendations from NACMHD; programmatic portfolio balance; and highly innovative scientific impact in advancing the science of minority health and health disparities.
- NIH and NIMHD are subject to a continuing resolution, so the appropriation for NIMHD remains at the FY24 level of $535 million, allowing NIMHD to maintain full funding for congressionally mandated programs including Research Centers in Minority Institutions, Improving Native American Cancer Outcomes, Native Hawaiian and Pacific Islander Health Research Office, the John Lewis Endowment Program, and research on HIV/AIDS.
- Looking at NIMHD R01 applications, the success rate declined in 2024. NIMHD would like to maintain the roughly 18% success rate from 2022 and is working to understand the reasons for the decline.
- In August, NIMHD staff participated in a collaboration site visit at Morgan State University in support of the President's Executive Order promoting excellence and innovation at Historically Black Colleges and Universities. It was led by the NIH Small Business Program Office with support from the NIH Path to Excellence and Innovation Initiative. The site visit included tours of facilities as well as presentations by Morgan State University researchers and students.

- In June, the NIMHD Division of Intramural Research presented on a range of topics at the Society for Epidemiologic Research Conference.
- In May, the Division of Intramural Research participated in the 2025 NIH Postbac Poster Day, and two NIMHD postbacs received outstanding poster awards.
- NIMHD had its inaugural epidemiology summer boot camp for fellows in June to August 2025, focused on epidemiology and methods in health disparities research.
- NIMHD partnered with the National Institute of Biomedical Imaging and Bioengineering and VentureWell on the Design by Biomedical Undergraduate Team (DEBUT) challenge, an annual contest that challenges undergraduate student teams to develop technology solutions for unmet needs of any area of healthcare. NIMHD sponsored a $15,000 award for HemBrace from Cornell University, a low cost reusable smart triage system for postpartum hemorrhage, which disproportionately affects women from specific racial and/or ethnic minority populations and those in low resource settings where timely diagnosis and intervention are more limited.
- The following science advances were made with the help of grants funded by and produced by NIMHD:
    - A recently published analysis of air pollution and hearing screenings found that prenatal environmental exposures may increase the risk of adverse birth outcomes such as neonatal hearing loss, which can hinder cognitive and language skills. It used a retrospective cohort of 141,000 live births in New Mexico and found a positive association between maternal residential exposure to particulate matter, specifically airborne metals, and newborn hearing screening failure. Infants born to American Indian or Alaska Native (AI/AN) mothers, mothers in rural areas, and those with lower education levels were more likely to fail the screening test. Air pollution is a modifiable risk factor for hearing loss; reducing metal particle exposure may help mitigate adverse developmental outcomes including hearing loss.
    - A study on pain and abstinence outcomes after a one-session digital smoking cessation intervention explored the relationship between pain and smoking. Chronic pain is strongly linked to cigarette smoking, and pain interference, the extent to which pain interferes with a person's daily life, is a potentially important factor. The study found that pain interference, but not intensity, was associated with higher odds of reporting smoking relapse at four weeks post-intervention. Targeting pain interference could help in developing tailored smoking cessation treatments.
    - A paper published in JAMA looked at suicide and overdose deaths following the August 2023 wildfires in Maui using vital statistics. The study found a 97% increase in combined suicide and overdose death rates in Maui alone, and a 46% increase overall in Hawaii. This study highlighted the importance of rapid deployment of suicide and overdose prevention strategies during these types of crises and during the recovery phase.
    - A study on falls, a leading cause of injury among older adults, evaluated a biofeedback exercise program that provided physical feedback, cognitive reframing, and guided exercises to reduce fall risk and improve physical activity. Participants who received the intervention showed significant improvement in the number of very active minutes per

day and modest improvement in fairly active minutes compared to the control group. Strategies are needed to sustain the benefits longer term.

- A pragmatic RCT evaluated strategies to improve cervical cancer screening rates. Women who are uninsured, live in rural communities, or come from specific racial and/or ethnic minority groups tend to be overdue for cervical cancer screening. The study compared telephone reminders to get screened in a clinic with telephone reminders and an at-home test kit. Those who received the at-home test kit were more than twice as likely to complete cervical cancer screening compared with those who only received telephone reminders, with a modest gain for those who also had a patient navigator.
- A study on socioeconomic disparities in breast cancer survival looked at the influence of Oncotype DX (ODX) genomic testing in data from the Louisiana Tumor Registry. There were lower proportions of ODX testing among Black than White patients, Medicare compared to private insurance, and low SES versus high SES. Low SES women were less likely to receive chemotherapy and had a higher risk of mortality. These findings highlighted the importance of targeted interventions to improve breast cancer outcomes for low-resource groups.
- A study on sugar-sweetened beverage behavior among adolescents and caregivers looked at the long-term impact of an intervention delivered in a school setting, combined with a text messaging strategy for their caregivers. Relative to the control group, those who received the intervention maintained reduced intake of sugar-sweetened beverages at 19 months.
- A pilot study tested a culturally tailored, family-based intervention for Chinese American families managing Type 2 diabetes. The intervention included behavioral coaching, family-oriented sessions, and 24 videos on diabetes self-management. The intervention group showed significant within group improvements in hemoglobin A1c (HbA1c) and self-management, as well as weight reduction that was not significant, possibly due to the small sample size. The study signaled the importance of culturally and linguistically tailored, family-centered health programs.
- Cigarette smoking has reached an all-time low in the U.S., but it's unclear if lung cancer mortality has also declined. A study estimated lung cancer rates and found a substantial decline, from 68.3 to 42.5 deaths per 100,000, but disparities persisted, with larger decreases in males than females, and the highest 2019 rates for Black and White populations in the Mississippi River watershed and Appalachia and among AI/AN populations in parts of the Midwest and Northeast.

Dr. Webb Hooper ended the report by noting that NIH is committed to supporting meritorious science in health disparities. Although the President's 2026 budget proposed eliminating NIMHD, the Senate and House proposed budgets maintain NIMHD, as well as the rest of NIH as currently organized. NIMHD was established through legislation, and there has always been bipartisan recognition of its importance. Science conducted at NIMHD is foundational to strengthening the well-being of the entire U.S population through interventions that improve health outcomes, enhance the productivity of society,

and reduce healthcare costs. Dr. Webb Hooper highlighted the importance of designing studies that are both scientifically robust and socially impactful, being as objective as possible, and ensuring that hypotheses are clearly grounded and have translational potential.

Statement of Understanding
https://videocast.nih.gov/watch=56883&start=4970

Dr. Priscilla Grant outlined the Statement of Understanding (SOU) between the NIMHD and Council, which summarizes how interactions between NIMHD and the Council will proceed over the next year. Dr. Grant gave overviews on certain sections of the SOU, including open/closed sessions, appeals, administrative decisions and actions that do not require Council recommendations, and options available to Council when reviewing applications. In closing, Dr. Grant reminded Council members of her contact information in case they have any questions.

Presentation

A community supported agriculture intervention to increase healthy eating with American Indian adults: the Go Healthy Study - Dr. Valarie Blue Bird Jernigan

https://videocast.nih.gov/watch=56883&start=5490

Dr. Valarie Blue Bird Jernigan presented on the Go Healthy Study, which examined the impact of a community supported agriculture (CSA) intervention on healthy eating among American Indian adults. It was conducted by her and her colleagues at the Center for Indigenous Health Research and Policy (CIHRP) at Oklahoma State University, with funding from NIMHD and the Osage Nation. There are persistent nutrition and health disparities among AI/AN populations, who have limited access to fresh fruits and vegetables. In 2020, the overall prevalence of food insecurity was 10.5% among U.S. households and 45.7% among AI/AN households. In addition, AI/ANs are nearly three times more likely to have diabetes compared to White persons, and 2.3 times more likely to die from the disease. AI/ANs are 50% more likely to be diagnosed with coronary heart disease than White persons. CIHRP's work takes an Indigenous food sovereignty approach, which acknowledges the right and responsibility of Indigenous people to healthy and culturally appropriate foods produced through traditional Indigenous practices. It is a community-led movement that addresses the need for nutrition approaches that are embedded within an Indigenous concept of health and wellness and self-determination, and it builds upon community strengths and cultural practices. One example of Indigenous food sovereignty is a CSA program, a system where community members purchase shares of a local farm's harvest in advance and receive regular boxes of seasonal, locally grown produce, providing benefits both for the farm and those community members. CSAs can provide financial stability to farmers, and they have been shown to support sustainable agriculture, encourage healthier eating, reduce food miles, increase fruit and vegetable consumption, and improve blood pressure and HbA1c levels. There had not been a formal evaluation of a CSA within American Indian populations.

The Go Healthy Study was designed to do just that, by assessing the impact of a tribal CSA on primary outcomes of blood pressure, blood serum lipids, and fruit and vegetable intake, as well as secondary outcomes of body mass index, HbA1C, skin carotenoid scores, food security, and health status. The study was designed as a randomized wait-list controlled trial with a community-based participatory research (CBPR) approach, with data collection at baseline and 6-month follow-up. The intervention included a weekly fresh produce box for each participant/household, which also included shelf-stable pantry items; a healthy eating and traditional foods curriculum, delivered in both English and Osage; cooking demonstrations, both videos and in-person; and a kitchen starter kit to address the lack of kitchen tools in some of the families. Statistical analysis included categorical variables such as baseline demographics and health characteristics as well as continuous variables such as the primary and secondary outcomes and linear mixed models to determine the effect of the intervention on within-person change for each outcome.

Looking at primary outcomes, fruit and vegetable intake as measured by the Healthy Eating Index (HEI) significantly increased in the intervention group from baseline to follow-up; that difference is also significant compared to the control group. Systolic and diastolic blood pressure significantly improved in the control group from baseline to follow-up, and diastolic blood pressure improved significantly in the control group compared to intervention group from the two time points. LDL-C also significantly increased in the control group. HbA1c significantly improved in the intervention group from baseline to follow-up and improved significantly compared to the control group from the two time points. Food security improved in both groups. Given there was an imbalance in baseline self-reported diabetes diagnosis between the intervention and control groups, a sensitivity analysis was performed adjusting for diabetes, the results of which were not different than the unadjusted results.

Summarizing the main findings, Dr. Jernigan noted that fruit and vegetable intake significantly increased in the intervention group compared to control group from baseline to follow-up. On average, HbA1c levels decreased by 0.35% in the intervention group. The intervention group saw greater reductions in HbA1C levels compared to the control group over time. Food security significantly improved in both groups, which was attributed to food sharing. In the control group, systolic and diastolic blood pressure significantly decreased over time, but the reason for this is unknown. Economic evaluations were also performed, including a cost-effectiveness analysis, cost-utility analysis, and cost-benefit analysis from a societal perspective. Compared to the control, the 4-month intervention was cost-effective, with an instrumental cost-effectiveness ratio of $1,998.56 per 1% HbA1c reduction and $102.01 per 1.0 HEI-2015 increase. The 4-month intervention yielded 9.0 quality-adjusted life years (QALYs) from HbA1c reduction and an instrumental cost-utility ratio of $16,326.97 per QALY. The 4-month intervention generated $370,852.42 to $641,859.99 worth of QALYs, $79,183.13 in productivity gains, and $208,874.75 in healthcare costs saved from averted diabetes cases, totaling $514,517.47 to $785,525.04 in net benefit. In the long run, net benefits of $12.86 to $19.80 million and $16.71 to $23.64 million would be gained over the decade, as well as $24.79 to $38.16 million and $32.34 to $45.71 million over the lifetime, with and without continuous intervention, respectively. The conclusions of the economic evaluation are that the Indigenous CSA dietary intervention improved glycemic control, promoted

healthy eating, and demonstrated short- and long-term relative efficiency of resource allocation, and is therefore worth investment for the American Indian population.

Dr. Webb Hooper said the study represents a really good example of how you can conduct rigorous science and conduct randomized controlled trials in the context of populations that experience health disparities. She asked about navigating the difference between Western scientific methods and Indigenous ways of knowing in terms of data collection and analysis. Dr. Jernigan talked about the importance of working with and incorporating the language and tribal elders, and taking all the components of the intervention directly from the ideas and recommendations and goals of the community members. Dr. Webb Hooper asked about other health outcomes or health challenges that this work might address going forward. Dr. Jernigan said they are interested in looking at how to scale this intervention up, referring back to the idea of needing to focus on third and fourth generation disparities research.

Dr. Adunyah asked how they had selected this particular location and population. Dr. Jernigan said they got involved after the Osage Nation approached them. Dr. Adunyah asked whether any other researchers at OSU had collaborated on the study, and Dr. Jernigan explained how the agriculture extension program had assisted with planning the investments and upgrades to the farm, with input from the Osage Nation, to enable the study to take place. Dr. Bauermeister asked about any hypotheses regarding the improvements that were seen in the control group. Dr. Jernigan noted they had seen, in earlier studies, demand for the intervention from control groups as well as significant increases in food security across both intervention and control, which the participants attributed to food sharing at community events and distributing extra foods to families that needed it. Dr. Stone asked about what makes this kind of research successful. Dr. Jernigan highlighted the critical importance of relationships with the program officers at NIH, given the way things can change and the potentially longer timeline when you're planning research in concert with tribes. She also talked about honoring tribal IRBs and the importance of making data ownership and usage agreements with the tribe early on to establish trust and understanding and ensure there won't be any surprises.

Closing Remarks and Open Session Adjournment
https://videocast.nih.gov/watch=56883&start=9090

Dr. Webb Hooper closed the meeting by thanking everyone for their comments, questions, and support of NIMHD. She adjourned the open session at 12:37 p.m.

END NOTE: REVIEW OF GRANT APPLICATIONS_ CLOSED SESSON

This portion of the 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.C., and section 1009(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. §§ 1001-1014).

Dr. Monica Webb Hooper called the Closed Session to order at 1:00 pm, September 5, 2025, Dr. Cotton led the second level review of grant applications submitted to NIMHD programs. Council members and NIMHD staff members were instructed on conflict of interest and confidentiality regulations. Council members and staff removed themselves from the meeting room and discussions for which there was a potential conflict of interest, real or apparent. The Council considered 396 competing applications requesting an estimated $ 141,264,402 dollars 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.