

**U.S. Department of Health and Human Services (HHS)
National Institutes of Health (NIH)
National Institute on Minority Health and Health Disparities (NIMHD)
National Advisory Council on Minority Health and Health Disparities (NACMHD)**

6707 Democracy Boulevard
Bethesda, MD

June 10, 2014
8:30 a.m. – 3:30 p.m.

Meeting Minutes

Council Members Present

Yvonne T. Maddox, Ph.D., Chair, Acting Director, NIMHD
Jasjit S. Ahluwalia, M.D., MPH
Judith Bradford, Ph.D. (*by teleconference*)
Eddie Greene, M.D.
The Honorable Kweisi Mfume
Valerie Montgomery Rice, M.D.
Lisa A. Newman, M.D., MPH, FACS, FASCO (*by teleconference*)
Jesus Ramirez-Valles, Ph.D.
Michael A. Rashid, MBA
Frank Talamantes, Ph.D.
Linda Thompson-Adams, Ph.D., RN, FAAN

Ad Hoc Members

Brian Rivers, Ph.D., MPH
Michelle A. Williams, Sc.D.

Ex Officio Members

Michael J. Fine, M.D., M.Sc.
William Riley, Ph.D.

Executive Secretary

Donna A. Brooks

Presenters

Lisa Fitzpatrick, M.D., MPH
Priscilla Grant
Joyce A. Hunter, Ph.D.
Richard Nakamura, Ph.D.
Nathan Stinson, M.D., Ph.D.
Pamela Thornton, Ph.D., MSW

CALL TO ORDER AND WELCOME

Yvonne T. Maddox, Ph.D., Acting Director of the National Institute on Minority Health and Health Disparities (NIMHD) called to order the Open Session of the 36th meeting of the National Advisory Council on Minority Health and Health Disparities (NACMHD) at 8:30 a.m. Dr. Maddox welcomed all Council members and other participants to the meeting.

CONSIDERATION OF FEBRUARY 2014 MINUTES

The Council approved the minutes of the February 25, 2014 meeting.

FUTURE MEETING DATES AND ADMINISTRATIVE MATTERS

The next NACMHD meeting is scheduled for September 9, 2014.

INTRODUCTIONS AND AGENDA REVIEW

Dr. Maddox welcomed a new *ex officio* Council member, William Riley, Ph.D., Acting Director, NIH Office of Behavioral and Social Sciences Research. Council members introduced themselves and described their areas of expertise.

NIMHD DIRECTOR'S REPORT

Dr. Maddox updated the Council on recent activities at NIMHD and across the NIH. Dr. Maddox became Acting Director, NIMHD, on April 1, 2014, upon the retirement of John Ruffin, Ph.D., who was honored for his service to NIMHD and the community. Dr. Maddox also expressed the Institute's sadness at the passing of Eddie Reed, M.D., who served as the NIMHD Clinical Director. Dr. Reed was remembered as an expert on ovarian cancer and its treatment, an outstanding physician, and a remarkable individual.

New NIH Staff:

- Hannah Valantine, M.D., is the first Chief Officer for Scientific Workplace Diversity at NIH. Previously, she was Senior Associate Dean for Diversity and Leadership and Professor of Cardiovascular Medicine, at Stanford University. NIMHD is working closely with Dr. Valantine on NIH Common Fund initiatives focused on scientific workplace diversity.
- Philip Bourne, Ph.D., is the first NIH Associate Director for Data Science. Dr. Bourne was Associate Vice Chancellor for Innovation and Industry Alliances and Professor of Pharmacology at the University of California, San Diego. Dr. Bourne asked NIMHD to participate on his Executive Committee, and Joyce Hunter, Ph.D., Deputy Director, NIMHD, is filling that role. In addition, he created the B2K Multi-Council Committee with membership from various NIH advisory councils to advise his office; NACMHD member Lisa Newman, M.D., has been appointed to the committee.

NIH Updates:

- The John Edward Porter Neuroscience Research Center on the NIH campus was dedicated on March 31, 2014. The building honors former U.S. Representative John Porter, who was a stalwart support of NIH and served for many years on the House Appropriations Committee that funds NIH.
- NIH established a new policy¹ that an unsuccessful A1 application can be submitted as a new, original application.
- Francis Collins, M.D., Ph.D., Director, NIH, and Janine Clayton, M.D., Director, Office of Research on Women's Health, published an article² in *Nature* on May 15, 2014, regarding sex differences in research on cell and animal models. New policies related to this issue will be announced beginning in October, and NIMHD expects to participate in the process of formulating these policies.

¹ NOT-OD-14-074 <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-14-074.html>

² Clayton JA, Collins FS: Policy: NIH to balance sex in cell and animal studies. *Nature* 509:282-283, 2014

- The Advisory Council to the NIH Director (ACD) met on June 5-6, 2014. Presentations to the ACD included: Dr. Valentine spoke about workforce diversity plans at NIH; Richard Nakamura, Ph.D., discussed the Peer Review Working Group that is looking at anonymity and review, including ways to modify biosketches to eliminate bias; Dr. Bourne discussed Big Data and how to mine the large quantities of data that have been collected; Renee Jenkins, M.D., Chair, NIH Working Group on the HeLa Genome Data Access Program described the NIH policy on the use of the HeLa cell database; and Jack Whitescarver, Ph.D., Director, NIH Office of AIDS Research, discussed the assessment of NIH AIDS policies and priorities. The ACD presented a report of the Physician Scientist Workforce that addresses challenges related to recruiting and maintaining physician scientists in the biomedical research workforce. Finally, the ACD discussed the in-depth review of the NIH Intramural Program. NIMHD's Intramural Program will not be fully reviewed as it is not fully staffed at this time; for example, a Board of Scientific Counselors is not yet in place.

NIMHD Staff Changes:

- Departing staff: Dr. Mark Williams; Toya Randolph, Ph.D.; Kaneisha Bailey; Scott Nolen, Ph.D.; and Debra Sowell. Kester Williams, Chief, NIMHD Office of Communications and Public Liaison, has taken an Intergovernmental Personnel Act position as a public policy fellow at the University of Maryland.
- New staff: Joan Wasserman, Dr.P.H., RN, Division of Scientific Programs; Adelaida Hoyos, Health Science Specialist; and Maryline Laude-Sharp, Ph.D., Acting Chief of the NIMHD Review Unit.
- Detailees and consultants: Deborah Henken, Ph.D., a detailee from the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development is serving as Acting Director, Office of Extramural Research Administration. Kelli Carrington, a detailee from the NIH Clinical Center, is Acting Director, NIMHD's Communications Office. Clarissa Wittenberg is consulting for the Communications Office. Steven Berkowitz is consulting on strategic budget and risk management support matters. Juanita Doty, Ed.D. is consulting for the NIMHD Program of Community Based Participatory Research and Collaboration. Alice Thomas, Ph.D., is advising on grants management operations.

NIMHD Updates:

- Dr. Maddox is currently serving as Acting Scientific Director for the NIMHD Intramural Program, and Sharon Jackson, M.D., an intramural investigator, is overseeing daily activities.
- An NIMHD employee incentive initiative has been created. This is a working group created to listen to the staff and assess what the Institute is doing well and what improvements could be made.
- Natasha Williams, J.D., Ph.D., NIMHD Legislative Liaison, is developing "The Friends of NIMHD Coalition." Many NIH Institutes have coalitions that allow these stakeholders to advocate for the institutes' priorities to multiple audiences, including Congress and potential funders.
- The first NIMHD portfolio assessment and operational planning process will take place at a staff retreat in late July, at which the Institute's activities for fiscal years (FY) 2015 and 2016 will be planned. One focus area will be the science of health disparities research—studying not just differences between populations but also the underlying reasons for those differences.
- The staff created a public health announcement for the Department of Health and Human Services on the NIMHD mission that all populations have an equal opportunity to live long and healthy lives.
- For the NIH Take Your Child to Work Day, NIMHD brought in a group of cyclists to speak to the children about safe and smart cycling.
- An NIMHD Peer Review Management Working Group comprising current and former heads of review units from three NIH Institutes and Centers, as well as the NIH Extramural Policy Officer, will work with Dr. Laude-Sharp to help NIMHD assess its peer review process.

- An Office of Community Based Participatory Research and Collaboration has been established to identify and develop innovative community prevention research collaborations This new office will explore the field of HIV/AIDS and the role the community can play in reducing health disparities in AIDS. Another area of focus will be the LGBTI community and its unique health needs.
- NIMHD-supported seminars over the last year included: Paula Braveman, M.D., MPH, who gave a presentation on the health of the black middle class presentations were made on training and extramural opportunities available through NIMHD; NIMHD staff gave invited scientific presentations at various universities; Irene Dankwa-Mullan, M.D., MPH, and Francisco Sy, M.D., Dr.P.H., are developing a special issue of the *American Journal of Public Health*.

NIMHD Budget and Other Legislation:

- The NIH FY 2014 budget is approximately \$30 billion, which is more than the sequestration FY 2013 budget but less than the pre-sequestration FY 2012 budget. The NIMHD FY 2014 budget of \$268 million follows the same pattern. The President's Budget for FY 2015 has been released but has not yet been brought to a vote in either the Senate or House. A key to increasing the NIMHD budget in future years is to communicate NIMHD success stories and the impact the Institute has made.
- A bill to establish a Historical Black Colleges and Universities Innovation Fund was sponsored by Senator Kay Hagan, D-NC, and has been referred to the Senate Health, Education, Labor, and Pension Committee.

Funding Opportunity Announcement: Limited competition for the NIMHD Exploratory Centers of Excellence Pilot Research Projects: applications were due June 19 and will be reviewed in July. NIMHD anticipates making about 10 awards for \$200,000 in direct costs for one year per project with an estimated \$3 million in total funding.

NIMHD Program Funding: Based on second level review at the February 2014 NACMHD meeting, the following grants were funded: one grant for \$225,000 was funded on basic science of health disparities; two awards for a total of \$281,000 were made for the SBIR RFA on Development and Translation of Medical Technologies to Reduce Health Disparities; two awards for a total of \$274,940 were made for the STTR RFA on NIMHD Technologies for Improving Minority Health and Eliminating Health Disparities; two awards for conference grants were made for a total of \$98,000.

Discussion:

- Detailees are paid from the budget of the originating Institute. NIMHD is recruiting for positions that are currently filled by detailees. In the future, NIMHD may send its own staff to other Institutes as detailees, providing opportunities to educate other Institutes about NIMHD activities and mission.
- A Trans-NIH LGBTI Working Group has been established to develop the NIH response to the Institute of Medicine report on the LGBTI population and its health needs. Larry Tabak, DDS, Ph.D., Principal Deputy Director of NIH, is leading this group.
- The health disparities strategic plan is on hold until NIMHD does its own operational planning process in July and has additional discussions with the trans-NIH community about the strategic plan.
- NIMHD is exploring several potential partnerships and collaborations. Dr. Maddox will meet with staff of the Division of Health Disparities at the Patient Centered Outcomes Research Institute (PCORI), to discuss possible PCORI support for the Institute's activities. In addition, the Institute is exploring opportunities to partner on AIDS research with the NIH Office of AIDS Research and the National Institute of Allergy and Infectious Diseases.

- The Institute is examining the structure of its Intramural Program and considering ways to focus the program on social determinants of disease rather than on much of basic and clinical sciences that can be done in other NIH Institutes and Centers.

UPDATE ON THE NIH COMMON FUND

Dr. Hunter updated the Council on activities of the NIH Common Fund program for enhancing the diversity of the NIH-funded workforce. The program is co-chaired by Dr. Maddox, Dr. Valentine, and Gary Gibbons, M.D., Director, National Heart, Lung, and Blood Institute. The co-chairs oversee a working group comprising representatives from across NIH. A trans-NIH group of project scientists has been assembled, and an external scientific panel of experts in mentoring, transformative training processes and other relevant areas is planned. As a Common Fund initiative, the workforce diversity program must be innovative, transformative, and involve NIH as a whole.

Pamela Thornton, Ph.D., MSW, described the three program initiatives:

- The Building Infrastructure Leading to Diversity (BUILD) initiative provides opportunities and resources for institutions to implement transformative, broad-based approaches to student training in biomedical research. In September, 15 planning grants were awarded for \$150,000 each. Approximately 10 BUILD awards for applications of up to \$3 million in the first year and \$5.3 million in years two through five are expected to be funded.
- The National Research Mentoring Network (NRMN) is intended as a consortium to enhance the training and career development of individuals from diverse backgrounds, to enhance networking and mentoring experiences. Seven planning grants were awarded at \$130,000 each. For the multi-year NRMN, the Common Fund expects to fund one award at \$2.2 million per year.
- The Coordination and Evaluation Center (CEC) provides the evaluation component for the mentoring and BUILD programs and fosters collaboration and dissemination of findings and lessons learned. One CEC award will be made with a budget of \$1.75 million.

Applications for the three initiatives will undergo peer review in July and review by both the NACMHD and the Common Fund in September. An awardee kick-off meeting is scheduled for October on the NIH campus. Geographic, scientific, and ethnic diversity will factor in the review and award process.

NIH PEER REVIEW

Dr. Richard Nakamura, Director, Center for Scientific Review (CSR), spoke to the Council about the peer review process at NIH. The mission of the NIH is achieved largely through awarding research grants to the extramural scientific community. At NIH overall, 83 percent of the budget is spent on extramural research. The CSR mission is to ensure that NIH grant applications receive fair, independent, expert, and timely reviews, free from inappropriate influences, so that NIH can fund the most promising research.

Peer review can take place at an Institute or the CSR. NIMHD reviews the majority of its grant applications within the Institute, although CSR reviews more than 70 percent of grant applications to NIH overall. Annually, more than 84,000 applications are reviewed by 17,000 reviewers aided by 236 CSR scientific review officers at 1,500 review meetings. NIH expects CSR to conduct reviews of the highest quality in a cost-effective and timely manner. CSR goals include continuous improvement in the quality, fairness, and efficiency of review, as well as development of the science of peer review. In 1979, the success rate for grant applications was close to 40 percent, and it has been declining since that time. Current success rates are low due to the flat NIH budget and the increasing number of applications.

In 2011, the Ginther paper³ reported a 10 percent difference in grant application success rates between African American scientists and the full sample. Based on the expected award rate difference between white and African American scientists, African American scientists were getting awards at 55 percent of the rate of white scientists. CSR examined the role of peer review in this differential. Among R01 applications at the A0 level, 60 percent of applications from white scientists were not discussed, whereas 73 percent of applications from African American scientists were not discussed. The difference in resubmission rates between the two groups could be entirely accounted for by this difference in initial scores. Moreover, given the scores, awards were equal for white and African American scientists. Thus, the data indicated that the problem was occurring in peer review or earlier, rather than at the award stage.

NIH responded quickly to the findings of Ginther *et al.* Among other actions at NIH, CSR immediately began increasing diversity on its study sections; currently, about 10 percent of NIH reviewers are underrepresented minorities. An office was created to study the peer review process. CSR issued two Challenges for new methods to detect bias (e.g., due to gender, race, ethnicity, institutional affiliation, area of science, and/or amount of research experience) in peer review and for strategies to strengthen fairness and impartiality in peer review. An Early Career Reviewer Program was created for training new reviewers. One new reviewer is placed on each panel for training; this person is given a light review load and is supervised by the scientific review officer and the study section chair. So far, 25 percent of participants have been from underrepresented populations. The Program has created a website, database, and video; CSR has engaged in outreach to R15 schools to publicize the Program. Anonymization and identity switching studies are underway to look for bias in the peer review process. CSR plans to evaluate relative advantage, as some scientists have suggested that award success is linked to having better networks. CSR is also interested in improving the overall quality of review. Potential areas of investigation include (1) a reliability study to compare scores of the same applications reviewed by different panels and (2) rank ordering pilot studies to assess whether new strategies for ranking applications would produce more reliable results.

Council members asked for an update on the Health Equity and Promotion study section that was formed about 5 years ago. Members were also concerned that the efforts to improve peer review might not be enough to make up for the loss of scientists who are no longer in the pipeline because they could not get initial funding for their research programs. Finally, the Council suggested that the CSR could examine bias related to other racial/ethnic groups in addition to African Americans and examine why the bias is greater with respect to African Americans.

HEALTH DISPARITIES IN HIV/AIDS: CHALLENGES AND OPPORTUNITIES IN MINORITY, UNDERSERVED POPULATIONS

Lisa Fitzpatrick, M.D., MPH, spoke to the Council about challenges and opportunities in health disparities in HIV/AIDS in minority, underserved populations. Rates of HIV infection in black Americans peaked in the late 1990s and have remained flat since then. In Washington, D.C., HIV is seen among black men who have sex with men, black gay men, and in the heterosexual population. The rate of HIV transmission from injected drug use (15.1 percent) has decreased drastically due to public health interventions, and substantial heterosexual transmission has been documented.

³ Ginther DK, Schaffer WT, Schnell J, Masimore B, Liu F, Haak LL, Kington R: Race, ethnicity, and NIH awards. *Science* 333:1015-1019, 2011

Challenges can be identified at every step on the continuum of care related to HIV: people are being tested late; after diagnosis, people are accessing care late and delaying treatment initiation; and people are not linking to or adhering to care. Many reasons for missed appointments have been identified, including denial and not wanting to talk about HIV, substance and alcohol abuse, untreated mental illness, and emotional issues, such as denial, shame, and embarrassment associated with HIV infection.

A critical issue is low community HIV literacy. In D.C., 12 percent of the population has never been tested for HIV; 45 percent believe AIDS is a death sentence; 43 percent believe there is a cure for HIV that is being withheld; 47 percent believe HIV is manmade; and 18 percent are unaware that HIV treatments exist. Other myths persist, such as believing that one can identify an HIV-infected person by how he or she looks. Finally, stigmas around sexual behavior continue to put people at risk.

The Centers for Disease Control and Prevention and the U.S. Preventive Services Taskforce have endorsed routine HIV screening, which reduces the stigma associated with it. Yet, routine testing has not been implemented in most health care settings. Providers are missing opportunities to identify HIV infections because of assumptions related to gender, age, or marital status, as well as reluctance to take a sexual history and discuss these topics with their patients. Issues related to insurance reimbursement have also hindered routine HIV testing, although that problem is now addressed by the Affordable Care Act. Some providers do not know the next step to take after making an HIV diagnosis. The issue of consent is another barrier to HIV screening. Routine testing is particularly important because acute HIV infection is associated with 40 percent of HIV transmissions, probably due to extremely high viral loads in the early stages of infection. Routine testing with technology that can identify acute infections, along with educating the primary care/family practice and emergency room communities, provides a critical opportunity. Early diagnosis and treatment of HIV infection could eliminate AIDS diagnoses. Operational research is needed to identify and address the barriers to HIV testing. The community also needs to be educated about strategies such as pre-exposure prophylaxis for preventing HIV infection before exposure and post-exposure prophylaxis for immediate treatment of someone who knows he or she has been exposed to HIV. Research and operations policies related to these strategies are needed.

Community engagement is needed to understand what it would take to engage people in their own health care and prevention and to overcome the stigma associated with clinical research in some communities. NIH could consider establishing a presence in underserved communities, perhaps through monthly lectures, in order to help people become familiar with NIH and its research programs. This direct engagement could help enroll more people from underserved communities in clinical studies.

In discussion with the Council, Dr. Fitzpatrick recommended that the most important issue that could be impacted by legislation is routine HIV screening. Ideally, HIV screening should be as common as checking for blood pressure, diabetes, or other major health issues. In addition, while HIV/AIDS is overwhelmingly a disease of gay men on a national level, in D.C., 50 percent of the people diagnosed with HIV or AIDS are black women, and only 33 percent of diagnosed men are gay men. Dr. Fitzpatrick's primary message to the community is that HIV is not just about being gay, but that it is about health. Finally, significant funds have been expended to educate health care providers on this issue, but challenges have persisted. Broader discussions are needed on why current efforts are not working and how to operationalize routine screening in diverse health care settings.

UPDATE ON STATEMENT OF UNDERSTANDING

Priscilla Grant, NIMHD Grants Management Officer, reviewed the Statement of Understanding between NIMHD and NACMHD members. The Statement outlines the Council membership and structure, as well

as actions that may be taken by the Council with respect to policies, concept clearance, and grant application review and resolution of appeals. The Statement also lists administrative decisions and actions that do not require Council recommendations. The Council unanimously voted to accept the Statement of Understanding.

RECOGNITION OF RETIRING COUNCIL MEMBERS, CERTIFICATES, AND CLOSING REMARKS

Dr. Maddox recognized three retiring Council members: Dr. Jasjit Ahluwalia, the Honorable Kweisi Mfume, and Dr. Jesus Ramirez-Valles. She thanked them for their efforts on behalf of NIMHD and the Council. These members will receive a Certificate of Appreciation signed by Sylvia Mathews Burwell, the new Secretary of Health and Human Services.

CLOSED SESSION

A portion of the meeting was closed to the public in accordance with provisions set forth in Sections 552b(c) (4) and 552b(c) (6), Title 5, U.S.C., and Section 10(d) of the Federal Advisory Committee Act, as amended, U.S.C. Appendix 2.

REVIEW OF GRANT APPLICATIONS

Dr. Maddox called the Closed Session to order at 1:39 p.m. Dr. Hunter led the second level review of grant applications submitted to NIMHD programs. The Council considered more than 327 applications requesting an estimated \$54,475,687 in total costs. Applications from four Requests for Applications (RFAs) were considered: NIMHD Basic and Applied Biomedical Research on Minority Health and Health Disparities; NIMHD Social, Behavioral, Health Services, and Policy Research on Minority Health and Health Disparities; NIMHD Resource Centers in Minority Institutions Infrastructure for Clinical and Translational Research; and Development and Translation of Medical Technologies to Reduce Health Disparities. For review of applications submitted to each RFA, Council members with conflicts of interest left the meeting room and did not participate in the discussion or vote. All funding recommendations for each RFA were made by a vote of eligible Council members. The Council considered applications for the NIH Omnibus Solicitations for Small Business Innovation Research (SBIR) and Small Business Technology Transfer Research (STTR), the program announcement for Research on the Health of LGBTI Populations, and conference and scientific meeting grants. Funding recommendations for these initiatives were made by the Council through *en bloc* voting.

ADJOURNMENT

Dr. Maddox adjourned the 36th NACMHD meeting at 3:09 p.m.

We hereby certify that, to the best of our knowledge, the foregoing minutes are accurate and complete.

/Dr. Yvonne T. Maddox/

Yvonne T. Maddox, Ph.D., Acting Director, National Institute on Minority Health and Health Disparities, NIH

/Donna A. Brooks/

Donna A. Brooks, Executive Secretary, National Institute on Minority Health and Health Disparities, NIH