NCIPC Board of Scientific Counselors
Open to the Public
January 11, 2024

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

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

Forty-Fourth Meeting
January 11, 2024

Virtual / Zoom Meeting
Open to the Public

Summary Proceedings

The forty-fourth meeting of the National Center for Injury Prevention and Control (NCIPC; Injury Center) Board of Scientific Counselors (BSC) was convened on Thursday, January 11, 2024 via Zoom and teleconference. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). Dr. Christopher Harper, NCIPC BSC Designated Federal Officer (DFO), presided.

Call to Order, Roll Call & Meeting Process, Welcome & Introductions

Call to Order

Christopher Harper, PhD
NCIPC BSC DFO
Senior Epidemiologist, Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Harper officially called to order the Forty-Fourth meeting of the NCIPC BSC at 10:08 AM Eastern Time (ET) on Thursday, January 11, 2024.

Roll Call & Meeting Process

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

Mrs. Lindley conducted a roll call of NCIPC BSC members and *Ex Officio* members, confirming that a quorum was present. Quorum was maintained throughout the meeting. Dr. Compton reported that he has long-term holdings in Pfizer Corporation and 3M. No other conflicts of interest (COI) were declared. An official list of BSC member attendees is appended to the end of this document as Attachment A. Mrs. Lindley introduced Stephanie Wallace, the Writer/Editor from Cambridge Communications and Training Institute (CCTI), who she explained would record the minutes of the meeting. To make it easier for her to capture the comments, Mrs. Lindley requested that everyone state their names prior to any comments for the record. She indicated that CDC Technicians would audio record the meeting for archival purposes to ensure accurate transcripts of the meeting notes. The meeting minutes will become part of the official record and will be posted on the CDC website at www.CDC.gov/injury/bsc/meetings.html. All

NCIPC BSC and *Ex Officio* members were requested to send an email to Mrs. Lindley at ncipcbsc@cdc.gov at the conclusion of the meeting stating that they participated in this meeting.

Welcome & Introductions

Christopher Harper, PhD
NCIPC BSC DFO
Senior Epidemiologist, Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Harper expressed gratitude to everyone for their commitment to injury and violence prevention and for taking time out of their busy schedules to participate in this important committee, which provides advice to the leadership of CDC and NCIPC on its injury and violence prevention research and activities. He welcomed new members Drs. Kaleem Malik, Mohammad Jalali, Hillary Kunins, and Keshia Pollack Porter and invited them to introduce themselves. Although unable to attend this meeting, Dr. Alexander Walley will be joining the NCIPC BSC as well. Dr. Harper also thanked and expressed gratitude to members of the public, pointing out that there would be a Public Comment session from 11:45 AM to 12:00 PM. At that time, Mr. Victor Cabada would be providing instructions for anyone wishing to make a public comment. In addition, he noted that those joining by phone without access to the slides through Zoom to www.cdc.gov/injury/BSC where the slides could be downloaded.

Approval of the May 4, 2023 NCIPC BSC Meeting Minutes

Christopher Harper, PhD
NCIPC BSC DFO
Senior Epidemiologist, Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Harper referred BSC members to the copy of the minutes provided to them with their meeting materials from the May 4, 2023 NCIPC BSC meeting. With no questions or edits noted, he called for an official vote.

Motion / Vote

Dr. Johnston made a motion, which **Dr. Shenoi** seconded, to approve the May 4, 2023 NCIPC BSC meeting minutes. The motion carried unanimously with no abstentions.

Director's Update

Samuel Posner, PhD
Acting Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Posner announced that until recently, he was the Acting Director of NCIPC. He was joined by Dr. Allison Arwady, who he announced recently became the new NCIPC Director. Dr. Arwady is a practicing physician and a leader in public health, an Alumni of CDC's Epidemic Intelligence Service (EIS) Program, and most recently served 4 years as the Commissioner of the Chicago Department of Public Health (CDPH) where she engaged in extensive work during the COVID-19 pandemic. Dr. Posner emphasized that Dr. Arwady has a longstanding interest in and is committed to the work that NCIPC does. He reported that there also have been other changes within NCIPC over the last year. Dr. Mandy Cohen joined CDC after the departure of Dr. Walensky in June 2023 and CAPT Christoper Jones left his role in August 2023 to become Acting Director, which prompted the search that led to hiring Dr. Arwady. Dr. Greta Massetti accepted a new position within NCIPC as the Principal Deputy Director in October 2023, a position that plays a critical role in supporting the strategic science of the Injury Center. Formerly, Dr. Massetti was the Branch Chief in Field Epidemiology and Prevention Branch in the Division of Violence Prevention (DVP) and has served in a number of leadership positions across the agency, including many during the COVID-19 pandemic response. Additionally, Dr. Arlene Greenspan retired in September 2023 and Dr. Corinne "Cory" Ferdon joined NCIPC as the Associate Director for Science (ADS). Dr. Ferdon has served in a variety of leadership roles at CDC, including Deputy Associate Director for Science for many years. She will have a critical role in overseeing all of the scientific processes for the Injury Center, including many of the activities that involve the BSC, such as priority development and management of the extramural research portfolio. Dr. James "Jim" Mercy, who had a long and illustrious career at CDC, retired in December 2023. Therefore, NCIPC is seeking a new DVP Director. Amy Peeples, who has been the Deputy Director for Management Operations for many years at NCIPC and has provided critical leadership in guiding the budget of the Injury Center over the last several years, is retiring in March 2023.

NCIPC is looking forward to announcing her replacement soon. Dr. Posner said that one of the great privileges he has had during the short time he has been at NCIPC was seeing how dedicated the Injury Center is to the mission, despite all of the staffing changes within NCIPC and CDC. With that in mind, he highlighted a couple of key successes over the last year (in no particular order). The Division of Overdose Prevention (DOP) awarded Overdose Data to Action (OD2A) funding to 49 states and the District of Columbia (DC), as well as a separate OD2A award to fund local organizations including 40 city, county, and territorial health departments. These cooperative agreements were tailored to address the evolving overdose epidemiology, close gaps in prevention activities, apply lessons learned from previous OD2A cooperative agreements, and reflect the differing roles and spheres of influence at the state and local health department levels. The Drug Free Communities (DFC) Branch awarded 163 new and competitive continuation applications, the largest number in the program's history. In recognition of celebrating 20 years of linking data to save lives, CDC, the American Public Health Association (APHA), and the Joyce Foundation partnered to host the inaugural National Violent Death Reporting System (NVDRS) Conference in Milwaukee, Wisconsin in May 2023. This 2.5-day conference was a great success, with 72 presentations and over 400 researchers, grantees, practitioners, and partners in attendance. Topics included health equity, intimate partner violence (IPV), youth and veteran suicide, violent deaths among LGBTQ+ (lesbian, gay,

bisexual, transgender, queer/questioning, intersex, asexual, and other) persons, substance use, violent deaths, data visualization, and advancements in data to action programming and policy. Dr. Posner emphasized that there is great energy and interest in having another of these conferences, which NCIPC is considering given the excitement about how well it went.

Throughout 2023, the Injury Center has expanded efforts to support firearm injury prevention research and surveillance and disseminate key results. The accomplishments include funding 12 new firearm research grants to address critical gaps, including policy analyses, and supporting 12 new FASTER sites to improve the timeliness of surveillance data from emergency departments (EDs) for firearm injuries. NCIPC also released the first summary of additional findings from the CDC-funded firearm injury prevention research centers, and developed the first national dashboard highlighting United States (US) firearm homicide and suicide rates and average daily numbers by month and year, and published updated costs of firearm injury estimates. President Biden issued an Executive Order directing the White House Gender Policy Council to develop the first ever National Action Plan to End Gender-Based Violence. The DVP co-chaired 2 of the 7 workgroups (WGs) to develop the content for the interconnected strategy pillars of the Action Plan. Specifically, DVP led the WGs on prevention and research and data. This work has ensured that DVP and CDC at large have a role in the implementation of this plan and the next steps for US efforts to move gender-based violence prevention work forward.

Finally, Dr. Posner recognized the NCIPC BSC members and thanked them for their invaluable expertise, insight, and commitment to the Injury Center. NCIPC appreciates the work that the BSC provided during the last meeting in May 2023, which helps the Injury Center improve the quality of its research and extramural work, developing a cascade of care framework and surveillance indicators to measure linkage of retention to care for substance use disorders (SUDs) and update and expand guidance for the identification of and response to suicide clusters and moving science data to violence prevention action, which has been very important. The BSC has conducted a lot of work, including the review of 7 extramural research awards that have included 27 applications being awarded of over $11 million. The topics include sexual violence (SV), new investigator awards for interpersonal violence impacting children and youth, tools for adolescent traumatic brain injury (TBI) patients, firearm injury and violence prevention, and risk and protective factors for polydrug use. He noted that during this meeting, the BSC would hear important presentations on the Injury Center's IPV research priorities from Drs. Estefan and Kearnes , who would discuss IPV as being a serious public health problem with prolonged, profound, and lifelong impacts. All too often, IPV is under-reported. It is known that many millions of people are affected by this form of violence every year in the US and more can be done to prevent IPV. CDC is committed to improving the surveillance of IPV and helping communities utilize effective strategies in order to achieve a world where everyone is free from violence.

Dr. Arwady greeted everyone, noting that it was her third day as NCIPC Director and that she was very excited to be there. She expressed gratitude to the BSC and emphasized that she had heard good things about the committee already. The team is excited about all of the research, working to fill gaps, and making sure that NCIPC is using science to drive programming. As she dives in and gets her head around all of this work, she will be looking to the BSC for the appropriate ways for guidance. She acknowledged those on the BSC she already knows and stressed that she was looking forward to meeting those she does not yet know. She expressed gratitude to Dr. Posner for serving in the interim role as NCIPC Director admirably and for being so welcoming.

Updated Intimate Partner Violence Research Priorities

Dr. Megan Kearns, PhD
Senior Scientist, Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Lianne Estefan, PhD, MPH
Lead Behavioral Scientist, Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

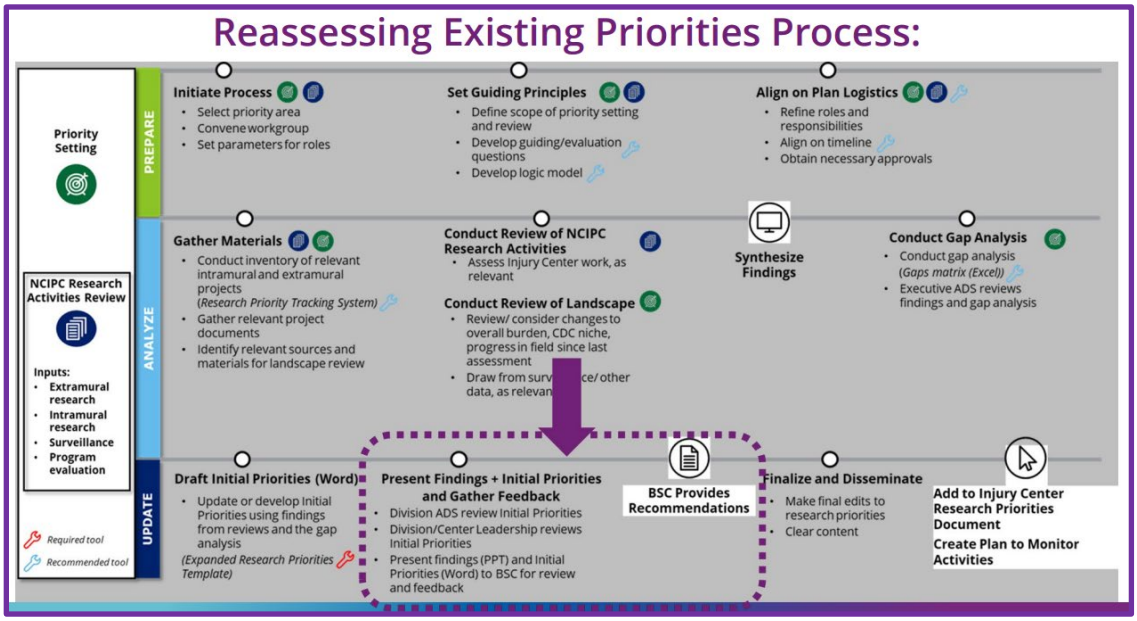
Dr. Kearns began by providing a brief summary of the process for identifying critical research gaps for IPV and teen dating violence (TDV) prevention research, which included an internal and external landscape review. She noted that NCIPC's research on IPV includes research on TDV because the type of IPV that occurs in adolescents is called TDV, and emphasized that TDV is always in scope and included in NCIPC's priorities for future IPV prevention research. This work has been supported by subject matter experts (SMEs) across DVP. Dr. Kearnes and Dr. Estefan have served as the Co-Leads for the internal IPV Research Priorities Core WG, which also has received support from the IPV Research
Priorities Consulting Group comprised of senior leaders from the Division and Center levels. This group has provided feedback at each step of the process, including input on the newly drafted priorities. As Dr. Posner mentioned earlier, there have been some recent leadership transitions. Drs. Greenspan and Mercy retired, while some of the consulting members assumed new positions within the agency. The IPV Research Priorities Core WG continues to work closely with senior leadership in this process.

In terms of the guiding principles for updating priorities, NCIPC has developed research priorities for each of its injury topic areas. These priorities focus on research goals and prioritize research that can have public health impact. The priorities are intended to encourage innovation and help focus CDC's public health expertise. The priorities include intramural and extramural work and are intended to cover the next 3 to 5 years. The goal is to demonstrate progress in that time period, even if a specific priority is not fully accomplished. In this way, the research priorities are meant to serve as a living document that is updated on a regular basis. NCIPC's current IPV research priorities[1] were first published in 2015 and are to: 1) identify and measure contextual typologies for TDV and adult IPV to guide prevention planning and improve evaluation quality; 2) examine the relationship-level (e.g., with peers, parents, romantic partners) and community-level risk and protective factors for TDV and adult IPV to identify potential opportunities for prevention strategies at these levels of the social ecology; and 3) evaluate innovative or promising prevention strategies to examine their short- and long-term effects on TDV and adult IPV.

In terms of NCIPC's process for re-assessing and updating existing priorities across of the Injury Center's injury topic areas, Phase 1 involved developing guiding questions and a logic model, as well as developing a detailed work plan outlining goals and responsibilities for the WG. Phase 2 involved gathering relevant materials and conducting a review of NCIPC research activities and the external research landscape to help inform a gap analysis for IPV prevention

[1] https://www.cdc.gov/injury/pdfs/researchpriorities/CDC-Injury-Research-Priorities.pdf#page=40

research. The process is now in Phase 3, which has involved drafting updated priorities and gathering internal and external feedback, including this presentation to the NCIPC BSC. The following graphic provides an overview of NCIPC's overall process for re-assessing and updating existing priorities across of the Injury Center's injury topic areas:



To help guide the process, 4 key questions were developed to help better understand what the most critical gaps are for IPV prevention and what should be prioritized going forward:

- ❑ What research has been carried out by the Injury Center to address IPV?
- ❑ How has external research addressed gaps and priority areas that align with NCIPC's research priorities for IPV?
- ❑ How has the field or overall burden changed since priorities were last assessed?
- ❑ What other issues or research questions have emerged from research and practice-based efforts?

To answer these questions, NCIPC conducted 3 major activities in Phase 2 that included an internal review of NCIPC research focused on IPV, an external landscape review, and interviews with IPV prevention partners that included academic researchers and partner organizations. The timeframe for this review focused on work produced since the last IPV priorities were published in 2015 to present. To share a few takeaways from the internal and external landscape reviews, for the internal review, the process included scanning internal data sources, including NCIPC's Research Priority Tracking System (RPTS) that includes scientific manuscripts produced by NCIPC; programmatic data from relevant PPTB programs, such as Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program, Preventing Violence Affecting Young Lives (PREVAYL), et cetera); surveillance reports from National Intimate Partner and Sexual Violence Survey (NISVS), Youth Risk Behavior Survey (YRBS), et cetera; and reports and supporting documents not in the RPTS (e.g., CDC products and webpages). Materials collected from these sources were used to evaluate progress in NCIPC's current IPV priorities and identify remaining gaps. A total of 83 articles focused on IPV were identified in the RPTS. The percentage of those articles that address the current priorities include 11% that identify and measure contextual typologies, 48%

that examine relationship- and community-level risk and protective factors, and 28% that evaluate innovative or promising prevention strategies. In addition, about 24% of these articles address health equity in some way.

The external landscape review focused on understanding research progress on IPV in the broader scientific literature, including IPV prevalence and trends, etiological research on risk and protective factors for IPV, efficacy and effectiveness research, and implementation science. Literature reviews and meta-analyses were prioritized whenever possible and again limited the search to articles published since 2015. An attempt was made to examine health equity science across all areas of the landscape review, as well as some additional cross-cutting themes, such as the impact of COVID-19 and emerging issues like technology-facilitated violence. The external landscape review identified 60 articles. The percentage of those articles that address the current priorities include 43% that identify and measure contextual typologies, 35% that examine relationship- and community-level risk and protective factors, and 32% that evaluate innovative or promising prevention strategies. In addition, about 42% of these articles address health equity in some way.

Connecting back to the guiding questions, since 2015, CDC intramural and extramural research has resulted in over 80 publications that address IPV prevention and align with one or more current research priorities for IPV. These studies have expanded knowledge on risk and protective factors for IPV and identified effective new prevention approaches (e.g., Dating Matters). External research also has expanded evidence areas that align with NCIPC's current priorities. For example, the review identified recent findings on relationship-level risk and protective factors. Less work has focused on community- and societal-level factors, which indicates some continued gaps and opportunities for future research in this area. Promising prevention approaches also have been evaluated, with most of that work having focused on youth in school-based settings. In seeking to understand how the field or overall burden of IPV may have changed since 2015, prevalence data continue to identify inequities in IPV in certain groups, including but not limited to people with disabilities, racial/ethnic minority groups, and sexual and gender minority groups. There also is emerging interest in understanding the burden of technology-facilitated IPV and TDV. Other issues or research questions have emerged from research and practice-based efforts. One example is the need to increase the understanding of the differential impact of prevention strategies to address the unique needs of communities experiencing IPV-related inequities in terms of what works for whom. Other identified gaps included the need for additional opportunities for intervention at the community- and societal-levels, including policy-based approaches and interventions that can address root causes of violence.

Dr. Estefan presented the results from the final component of the Phase 2 activities, which included conversations with researchers and partner organizations. The goal of these conversations was to engage external IPV prevention partners to gain additional perspectives on the current priorities for IPV research and identify future directions for the field. Conversations were conducted with the following:

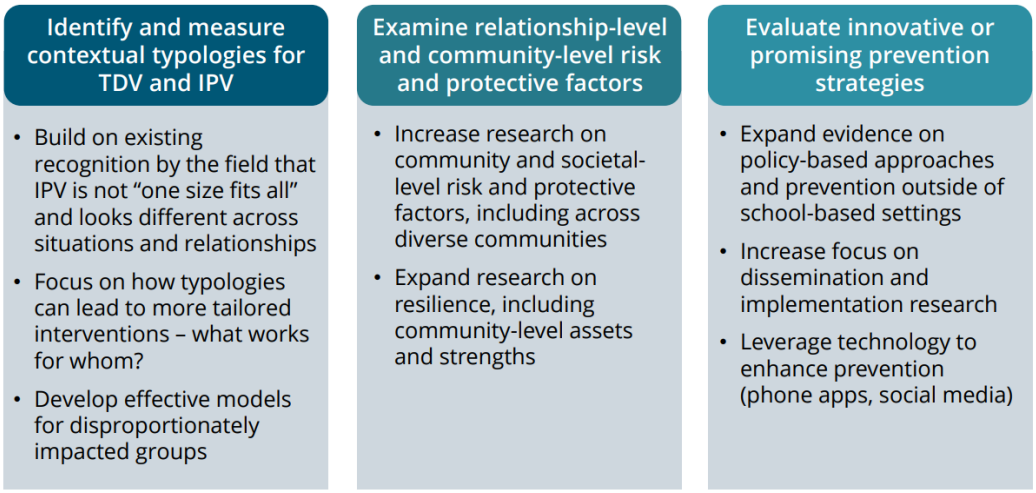
Academic Researcher Conversations (n = 5)
- ❑ Shanti Kulkarni, PhD: University of North Carolina Charlotte (UNC Charlotte)
- ❑ Emily Rothman, ScD: Boston University (BU)
- ❑ Abraham Salinas-Miranda, MD, MPH, PhD: University of South Florida (USF)
- ❑ Jeff Temple, PhD: University of Texas Medical Branch (UTMB)
- ❑ Tiara Willie, PhD: Johns Hopkins University (JHU)

Partner Organization Conversations (n = 3)

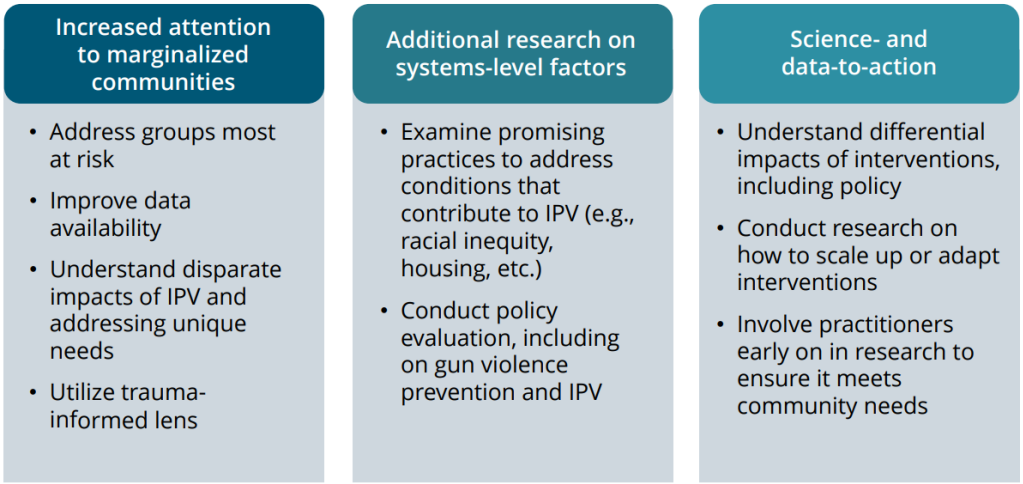
- ❑ National Resource Center on Domestic Violence (NRCDV)
- ❑ Futures Without Violence (FUTURES™)
- ❑ National Network to End Domestic Violence (NNEDV)

Researchers were selected who represented different areas of IPV and TDV expertise and had a range of familiarity with CDC funding. These conversations focused on recent progress of CDC's IPV research priorities; opportunities for future research, including how to have a stronger focus on health equity science; and challenges in addressing critical research gaps. The national-level partner organization conversations focused on prevention innovations happening in the field; research gaps and needs that are emerging from practice; and impacts of CDC-funded IPV research on the field.

Researcher feedback was organized by current research priorities as outlined in the following graphic:



Partner organization feedback also was organized by current research priorities as outlined in the following graphic:



After completing the data gathering from all of the research, internal documents, and conversations, a gap analysis was conducted. Multiple gaps were identified in research that emerged consistently across the data collection mechanisms. There is a great need for research on groups experiencing inequitable burden of IPV and TDV. These groups include, but are not limited to, people with disabilities, sexual and gender minority groups, racial/ethnic minority groups, pregnant or parenting adolescents, rural populations, and people experiencing homelessness. Gaps were identified in this area for all types of research (e.g., etiological, evaluation, and implementation). Technology-facilitated IPV also emerged as an important gap. Because this is a newer method of perpetrating IPV and TDV, research is needed on risk and protective factors and evaluating promising approaches that address technology-facilitated IPV and TDV. Continued research also is needed on risk and protective factors more generally, particularly in terms of IPV risk and protective factors at the community- and societal-levels, including social and structural determinants of health. Gaps also remain in evaluation research, which is particularly salient for evaluation research of strategies that occur in different settings and for different types of approaches than have been evaluated in the past. These could include programs at the family and peer network levels, including generational approaches for the prevention approaches that are delivered virtually or online. Finally, more implementation research is needed. Relatively less work has been done in this area for IPV. Critical research gaps that remain include examining adaptations for specific groups and understanding how to scale-up evidence-based interventions.

All of this work in Phase 2 informed the proposed new priorities. The proposed new priorities were drafted based on the gap analysis and were reviewed by internal Division and Center leadership, revised, and then reviewed externally by both federal and non-federal partners. Based on this process, CDC's proposed priorities for IPV will focus on the following areas:

- ❑ Etiological research on risk and protective factors for IPV
- ❑ Evaluation research to expand the evidence base for IPV prevention
- ❑ Implementation research that can guide prevention planning

All research priorities will center health equity and prioritize the gaps identified that related to social and structural determinants of health. The first 2 proposed priorities reflect a similar to the current priorities, while the third one focused on implementation science is the next step in NCIPC's current typology research priority. The new implementation science priority will help to better understand what works for whom. The new proposed priorities and example research questions for each are as follows, with the understanding that a lot more research may fall under each priority:
:

1. **Advance research on risk and protective factors for IPV, especially factors at the community and societal level that contribute to inequitable risk.**

   Example Research Questions:

   1.1: What community-level risk and protective factors (e.g., neighborhood disinvestment and collective efficacy) contribute to risk or protect against IPV perpetration among different populations and communities?

   1.2: How do structural determinants of health (e.g., economic, social, and organizational policies) increase or decrease risk for IPV and contribute to inequitable burden?

1.3: How have historical, collective community, or intergenerational forms of trauma (e.g., ACEs) contributed to inequities in risk for IPV?

1.4: What protective factors (e.g., cultural and community strengths) operate among communities experiencing inequitable burden of IPV?

1.5: What modifiable risk and protective factors increase or decrease the likelihood of technology-facilitated TDV and IPV perpetration, and how do these factors overlap with risk and protective factors for TDV and IPV perpetrated in person?

2. **Evaluate innovative or promising prevention strategies to examine their short- and long-term effects on TDV and IPV.**

   Example Research Questions:

   2.1: What prevention approaches effectively reduce risk and enhance protective factors for TDV and IPV at the community- and societal-levels of the social ecological model?

   2.2: What social, economic, and organizational policies can prevent TDV and IPV, mitigate its consequences, and reduce inequities in IPV?

   2.3: What programs, policies, and practices are effective at preventing technology-facilitated TDV and IPV?

   2.4: What are the effects of practice-based TDV and IPV prevention approaches that have substantial uptake in practice but lack evaluation research evidence, particularly in communities experiencing inequitable burden of IPV?

   2.5: To what extent do effective or promising TDV and IPV prevention approaches (e.g., evidence-based approaches for related forms of violence) demonstrate sustained or strengthened effects over time when additional follow-up is conducted?

3. **Identify factors that influence effective implementation of IPV prevention strategies to guide prevention planning and inform more tailored prevention efforts.**

   Example Research Questions:

   3.1: What are the essential elements or core components of evidence-based IPV and TDV prevention approaches, including policies?

   3.2: How can evidence-based TDV and IPV prevention approaches be adapted to be effective for other populations, in other settings, and using other delivery methods (e.g., digital apps or online programs), particularly among communities experiencing inequitable burden of IPV?

   3.3: What is the economic impact (e.g., the cost-effectiveness and cost-benefit) of evidence-based TDV and IPV prevention approaches?

3.4: What contextual factors (e.g., training and technical assistance; organizational factors; cultural factors) influence uptake, implementation, adaptation, and sustainability of evidence-based TDV and IPV prevention approaches, particularly among communities experiencing inequitable burden of IPV?

3.5: How can evidence-based TDV and IPV prevention approaches be scaled up to have community- or population-level impact, particularly for groups experiencing inequitable burden of IPV?

The following questions were posed for the BSC's consideration, discussion, and feedback regarding the proposed new priorities:

Research at the Community- and Societal-Levels
- ❑ What challenges exist for addressing research gaps in IPV/TDV prevention at the community- and societal-levels of the social-ecological model, especially gaps focused on social and structural determinants of health?
- ❑ How can CDC support the research community in overcoming these challenges?

Addressing Inequities in IPV
- ❑ What research should CDC prioritize in the next 3-5 years that can support the greatest advances in health equity science and reducing inequities in IPV/TDV?

Implementation Research
- ❑ What are the greatest opportunities and challenges for advancing implementation science for IPV/TDV prevention efforts in the next 3-5 years?

Discussion Points

Dr. Caine noted that while this sounded very encouraging, he wanted to place it at the macro level in terms of what impact the research activities have had on IPV in the broader sense over the last 8 years since the priorities were last set.

In terms of overall prevalence and trends, **Dr. Estefan** said that when the internal and external landscape reviews were conducted, the patterns in IPV prevalence were consistent over time. There was some preliminary evidence in the surveillance data suggesting that IPV potentially increased during the pandemic, and there was some increase in the prevalence of severity without previous IPV and some evidence of an increase in sexual and gender minorities and non-binary individuals. There was a lot of increased focus, and the need for increased focus, on under-studied and marginalized populations.

Dr. Kearns added that within the partner conversations, they definitely heard about the influence of CDC-supported research on IPV in that CDC research has been very influential and is often looked to. The "Technical Packages" that are now called "Resources for Action" have been a very important tool for the field and are informed by the best available evidence for IPV prevention.

Dr. Estefan agreed that the practitioners in the field noted that CDC's work has impacted the field, both in terms of the conversations and the proposed research priorities that were shared with them for input. It also was identified that CDC's data and evaluation research has helped inform policy conversations and advocacy for policy focused on IPV that CDC is not permitted to do. Thus, there has been quite a bit of impact.

Dr. Caine asked whether NCIPC tracks uptake of prevention activities across states, counties, and cities.

Dr. Estefan said that while she did not know whether they have a systematic way of doing that across everything, there is active tracking of the CDC-developed Dating Matters TDV prevention model. The Division's Policy Office may have more information on tracking as well.

Dr. Kearns added that detailed information is tracked on the DELTA program funding that is allocated to state domestic violence coalitions in terms of what they are implementing. The point about broader uptake is why the implementation science-focused priority is so important. Some of the example research questions speak to better understanding of uptake and scale-up. Hopefully, future work will specifically look at uptake and scale-up.

Dr. Estefan added that there soon would be additional NISVS data from 2023, which will identify more of what is occurring in the broader field.

Dr. Johnston applauded the systematic way that DVP approached finding out the state of the science retrospectively. Looking prospectively, artificial intelligence (AI) is going to affect and touch on almost every aspect of persons' lives. She asked whether the landscape assessments included the use of AI to target violence against individuals.

Dr. Estefan said that while she did not remember AI coming up specifically since the internal and external reviews were retrospective, it could be included because that is clearly the way technology is headed. Though she did not know whether AI is being used to perpetrate IPV or TDV at this time, it is an interesting question. Another interesting question pertains to whether there are ways to use AI to prevent IPV or TDV that would fit right into DVP's evaluation priorities.

Dr. Kearns added that some of the research that examined deep-fake pornography has been incorporated from AI involvement and that type of perpetration. It is a great example of why it is so important. The technology space evolves faster than research often does, which is one of the reasons it has been such an emerging issue in the last few years. There is a lot to unpack and the opportunities for perpetration are changed by technology. The external partner feedback suggested that there is a lot of enthusiasm for explicitly calling out the need to expand work in that space.

Following up on Dr. Caine's question, **Dr. Ondersma** asked to what extent there are good data on the proportions of people affected by IPV or TDV who seek help and who receive help, and the extent to which that is being tracked in a way that will allow for assessment in 3 to 5 years to demonstrate that a dent has been made in these outcomes. Those data are pretty shocking with regard to substance use and drive important approaches to addressing substance use.

Dr. Kearns responded that it is known from the data how underreported IPV is. While they want the norm to change in the direction of encouraging more reporting of perpetration, that can make it hard to assess prevalence in terms of whether there is simply more reporting or if perpetration prevalence is actually changing. It seems like this would be very important with regard to the classic formula that efficacy in changing something is a combination of the reach and impact of the interventions. If the reach is not known and assumption is made based on available data, perhaps there are huge swaths of affected people who are never seeking or accessing help.

Dr. Estefan did not recall anything coming up in the review, but data for IPV remains a challenge. They can look into this with their surveillance colleagues to determine whether they have more information to help better answer that question.

Dr. Basile added that in the past, NISVS has included questions about disclosure of IPV. It is very low as compared to other health issues for which there is less stigma and fear. They have relied primarily on self-report data in terms of assessing whether self-report data regarding reports of IPV are increasing. This is an important question.

Dr. Ondersma said he would make a distinction between disclosure to doctors or others and actually seeking help, which would be a separate issue.

Dr. Estefan emphasized the need to do more research and work with marginalized populations and other groups that have not had as much research focused on this topic. Those also are groups who may not report or may not seek help for a variety of reasons, which could contribute to underreporting.

Dr. Basile said that questions are asked routinely in NISVS about the impact of the violence. Some of those questions involve the need to seek frontline healthcare services and they follow that over time.

Dr. Ondersma said that in a representative sample, proactively sought, not coming from those who already have disclosed, asking whether they had experienced this, and asking those who experienced it whether they had called any of the hotlines, it would surprise him that those numbers, regardless of recognition or disclosure, are high such that most people who have experienced this are calling the hotline.

Dr. Basile clarified that the way they ask the question pertains to the need to seek services. These are lifetime experiences, so they do not know when they are happening. While they typically track lifetime experiences and need for services, they have begun to ask “over the last 12 months” for some of the questions and need to do that more.

Dr. Ondersma confirmed that this matches how it is done in substance use among those who meet the criteria for SUD in terms of the proportion who have sought treatment and what proportion have received it. The vast majority have neither sought nor received treatment.

Dr. Nation emphasized that one thing he always has appreciated about NCIPC’s work is their ambition. Even in narrowing down some of the problems, what Drs. Kearns and Estefan outlined is still a lot. He asked them to talk more about how they are thinking about priorities. He saw a tension between breadth and depth in terms of wanting to understand what they are doing better as opposed to wanting to expand to try new things or include other populations. He

wondered whether they had more specific ideas or recommendations about how they might set priorities.

Dr. Kearns responded that there has been relatively less work on addressing inequity and implementation research, so there are a lot of opportunities to grow the evidence in these spaces. Given that this could move in a million different directions, they were interested in hearing the BSC's perspective on what might be the most immediate priorities in these areas. She stressed that this is meant to be a living document that is updated on a regular basis and that they are trying to show progress in the next few years versus "checking the box" and moving on from these priorities in that timeframe. The example research questions represent the program's preliminary thoughts about what might be important first steps, but those questions are still very big.

Dr. Estefan emphasized that this is meant to be a living document not only for CDC, but also to help those in the field focus their work. In their conversations from researchers and practitioners that they often look to CDC's research priorities to thinking about how to focus their own work. It is clear that all of the examples cannot be achieved in the next 3 to 5 years, but hopefully there will be enough stimulation in the various areas to conduct research across the board. They also would appreciate the BSC's thoughts on where the priorities might be and how to narrow or focus.

Dr. Shenoi expressed appreciation for the laying of a roadmap for how to advance the science in the coming years. He asked whether CDC reviewed similar research conducted by other federal agencies, such as the Department of Justice (DOJ) in terms of successes, barriers, et cetera. Interpersonal violence impacts people in the criminal justice system in terms of restraining orders and so forth.

Dr. Estefan agreed that interpersonal violence, IPV, and TDV affect multiple federal agencies. The NCIPC review focused primarily on internal documents because they were focused primarily on the prevention space. While they did not specifically review documents from other federal agencies, if they came across papers and manuscripts, they certainly included them. They had conversations along the way and had reviewers for the proposed priorities from multiple federal agencies, so they did get their perspective about what worked, challenges, what they would suggest, et cetera. Those recommendations are incorporated as possible in the proposed recommendations.

Dr. Kearns added that the feedback from other federal partners came to them late in the year, so they are planning follow-up conversations with some of those partners, because they were excited about the proposed priorities and wanted to share some of the ways their work might fit in or where there might be opportunities for collaboration. Hopefully, this will stimulate continued conversation.

Dr. Johnston pointed out that the ability to track people in a system over time to assess where people are falling off and how effective interventions are speaks to process. It seemed to her that the area of implementation research was about process evaluation, which often is given short shrift compared to outcome evaluations. The inclusion of specific metrics around seeking help, obtaining help, benefitting recidivism, et cetera and going through the timeline of the process would be one way to try to address getting at least a baseline assessment of how the work that is being done is making a contribution to improvements.

Dr. Compton indicated that interagency collaboration is an area that the National Institutes of Health (NIH) has taken to heart with some success in research programs. The National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH), National Institute of Child Health and Human Development (NICHD), and probably a few others looking broadly at the NIH portfolio have some focus on this topic. NIH appreciates NCIPC's leadership in moving this forward as a coordinated effort and looks forward to seeing the products of the new priorities. Clearly, the priorities overlap with substances in obvious and subtle ways in terms of victimization due to use of substances and substances as a product of having been a victim. Both of those will be major themes that NIH will look for within the research that is supported.

Dr. Estefan said that they were very excited to receive feedback from the reviewers and the number of other federal agencies that were interested in discussing what could be done together.

Dr. Harper noted that Dr. Rowhani-Rahbar has done a lot of work around policies specifically looking at IPV as one of the outcomes and crosscutting lessons. He asked whether Dr. Rowhani-Rahbar could share any lessons or opportunities from that project that focused on tax credits that could help NCIPC better understand how gaps might be addressed that focus specifically on social and structural determinants of health.

Dr. Rowhani-Rahbar said that their U01 cooperative agreement examine the impact of the Earned Income Tax Credit (EITC) policy on multiple forms of violence on which CDC was focusing at that time, one of which was IPV. In terms of the impact EITC and different forms of violence was that one of the major gaps in understanding is the relationship between EITC and different forms of violence is IPV. They did not find the same positive impacts of the EITC on IPV as they did for reduction of child maltreatment (CM) and suicide ideation and attempts. They hypothesized and found that in terms of implementation and uptake of policies, there are clear gaps and shortcomings that need to be addressed. For instance, there are some differences across states and how people go about claiming the EITC. There is a wide range of opportunities in terms of looking at implementation and uptake based on the design of state policies in terms of their potential impact on different forms of violence. He also highlighted the incredible interconnectedness of gun violence and IPV. It is known that a striking number of fatal mass shootings have a domestic violence- or IPV-related cause at more than 50%. There is an incredible opportunity for the field moving forward to understand the intersection of domestic violence, IPV, and gun violence across the age spectrum from TDV to older adults.

Dr. Harper emphasized that this was a great presentation and that he is a big fan of discussions with the BSC members. He requested that in closing this session, perhaps Drs. Estefan and Kearns could walk the BSC and the public through the next steps.

Dr. Kearns indicated that they definitely want to continue to gather feedback from the BSC before finalizing and releasing the proposed new priorities. All of the feedback received internally and externally will be incorporated and what was presented during this session will be revised and submitted to the CDC clearance process for release later in 2024.

Dr. Harper noted that he and Mrs. Lindley would be working with NCIPC's Divisions to develop agendas for upcoming meetings, so he invited the BSC members to provide feedback on topics they would like to hear about during upcoming BSC meetings.

Dr. Caine thought it would be useful to hear updates from each NCIPC Division on whether/how various projects have made a difference in terms of their specified deliverables. He thinks it is critical for the BSC to have a better sense of outcomes.

Dr. Baldwin reported that the DOP set up a rigorous evaluation process for its OD2A program and said that he would be happy to work with Dr. Harper and the team to determine how the DOP staff could present on the evaluation protocols in place for OD2A in order to receive thoughtful feedback from members of the BSC.

Dr. Nation observed that NCIPC and the National Institute of Justice (NIJ) have made community violence an important priority, with part of the distinction being law enforcement- versus public health-oriented interventions. At the same time, it seems like there are places and maybe reasons for these two to intersect more purposefully as opposed to having a hard line between them. He wondered whether it would be possible to have a conversation about whether these two intersect and, if so, how the agencies that are responsible for these two approaches think about their collaborations.

Dr. Simon responded that a lot of thought has been given to this and considerable progress has been made in terms of the context of the White House's and Administration's priority focused on community violence prevention. NCIPC has established strong relationships with the folks who are leading that initiative within the DOJ, such as Eddie Bocanegra. To provide a concrete example, NCIPC worked closely with Eddie Bocanegra and others within the DOJ to get their input in order to update the "Youth Violence Prevention Technical Package" to develop a "Community Violence Resources for Action" to ensure that it resonates with the DOJ's grantees. The DOJ invited Dr. Simon and others to present to their grantees about the public health approach, key priorities, and prevention opportunities. The "Community Violence Resources for Action" includes new content that has not been included before pertaining to restorative justice, the school-to-prison pipeline, and the focused deterrence approach. The intent is to explain how community violence prevention from a public health perspective can complement the work of law enforcement to make communities safer and make the job of law enforcement easier. They have agreed on some key messaging like that as well. He agreed that there is more that they could do and said he would be happy to speak further with the BSC about that.

Dr. Nation thought this was exciting to hear and expressed his hope that it would filter down into communities, because often still is a divide between public health and law enforcement at the community level. Perhaps with this type of collaboration, there would be some on-the-ground collaboration occurring as well.

Dr. Harper noted that with Dr. Mercy's retirement, Dr. Simon and Reshma Mahendra are currently serving as Directors for the DVP and will have an important role in helping to shape the work of the BSC and violence prevention overall. He invited BSC members to submit additional thoughts about future agenda topics to Mrs. Lindley at ncipcbsc@cdc.gov.

Public Comment Session

Christopher Harper, PhD
Senior Epidemiologist, Office of Science
NCIPC BSC DFO
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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

Overview

Dr. Harper thanked everyone for their participation in the BSC meeting and indicated that all public comments would be included in the official record and would be posted on the CDC website with the official meeting minutes at CDC.gov/injury/bsc/meetings.html. He also pointed out that while they would not address questions during this public comment period, all questions posed by members of the public would be considered by the BSC and CDC in the same manner as all other comments. He invited those who did not have an opportunity to speak in person to submit their comments in writing to ncipcbsc@cdc.gov and called upon Mr. Cabada to facilitate the public comment session.

Before opening the floor, **Mr. Cabada** provided information and instructions related to public comment. In order to hear as many public comments as possible, he asked everyone to keep their comments to no more than 2 minutes and noted that a timer would be displayed. Following specific instructions, he thanked members of the public for their interest and engagement and began the session.

Public Comment

Elizabeth Fitelson, MD, Psychiatrist
Associate Professor of Psychiatry
Columbia University

Thank you so much. I am Elizabeth Fitelson. I am a Psychiatrist and I am an Associate Professor of Psychiatry at Columbia University. I run our Women's and Reproductive Mental Health Program. I also helped co-found a Domestic Violence and Mental Health program in New York City's Family Justice Centers (FJCs) that extends to all 5 boroughs and now into the Domestic Violence Shelter System. I also sit on the Maternal Mortality Review Committee since 2018. I am attending the meeting today along with another colleague, Qing Li, who has more specific recommendations. But, I do want to comment on the intersection between maternal mortality and IPV and advocate for more collaboration within CDC and with other agencies to facilitate a better understanding of the intersection between these two major problems. As you very likely know, homicide in this country is the leading cause of death during pregnancy or within a year post-partum. About 60%, over 50%, of these homicides are committed by a current or former intimate partner. As part of the Maternal Mortality Review Committee in New York City, we review every single case of a pregnancy-associated death, including overdose and mental health-related deaths, as well as IPV deaths. The granular details of the MMRCs with those case reviews is really invaluable information and could really add to the research and

understanding of IPV in the broader context as for the research priorities. As well, the expertise of the CDC in this area could really help with forming the recommendations of MMRCs. On a separate note, and I'll wrap up, I do hope that with the priorities with IPV that there is some way of tracking the impact of abortion restrictions in this country on the rates and consequences of IPV. Thank you very much.

Qing Li, MD, DrPH
OB/GYN-Trained Perinatal Injury Epidemiologist

Hello. This is Qing Li. Just now my colleague, Elizabeth Fitelson, presented her important perspective. I am Qing Li, OB/GYN-trained Perinatal Injury Epidemiologist with an Injury Center dissertation award on pregnancy and intimate partner violence, IPV. I really enjoyed the conversation on the updated IPV priorities. Pregnancy or parenting adolescents were mentioned. Among the 3 partner organizations, an important partner organizations, internal partners National Center for Chronic Disease Prevention and Health Promotion and Division of Reproductive Health were not mentioned.

So, my subject matter is pregnancy-associated violent deaths. Twenty years ago, the 42 US Code § 247b-12 Safe Motherhood passed in 2001 that provided the CDC Director with authority to investigate the intersection of violence and maternal mortality. However, what was written in law has not been implemented into activities at CDC. The U.S. leading causes of pregnancy-associated deaths are drug overdose, homicide, suicide—all of which have been increasing in the past decade. Starting with IPV, the likely risk factors for those causes include depression, IPV, suicide ideation, but haven't been monitored in injury-related maternal early warning systems. As opposed to core obstetric causes, we have been developing a public health approach to advancing and integrating systems and models of care to address mental behavioral health issues and include upstream factors for prevention. Right now, each violent death for pregnant or post-partum women has been captured by separate systems at the CDC. The Injury Center has the NVDRS and SUDORS (State Unintentional Drug Overdose Reporting System) and the Maternal Mortality Review Information Application (MMRIA) from the Division of Reproductive Health (DRH). The DRH has the data but hasn't investigated pregnancy-associated violent deaths. There was an analysis by injury experts recently, but Dr. Linda Saltzman passed away in 2005. Dr. Alex Crosby, who was invited to contribute a report in 2017, has retired. In most states IPV hasn't been quantified in reports from Maternal Mortality Review Committees, (MMRCs). Injury researchers couldn't access MMRC data.

During the 20-year gap, we have proposed 6 items. First, integrate data systems to develop a coordinated response. The MMRIA data system and SUDORS are separate at CDC. The lack of data integration and system coordination potentially reduplicates work with high costs and low accuracy. We need a structured collaboration guided by the CDC leadership, such as the Chief Medical Officer Debra Houry, who published on IPV and pregnancy, could lead a workgroup similar to the BSC Opioid Workgroup. Hearing from Debra Houry regarding maternal death was scheduled for last May 11th, but has been postponed. Second, include injury experts in activities from the DRH to strengthen monitoring and evaluation of violence. Third, review projects on IPV and maternal deaths funded by CDC from 2001 onward in compliance with the provision authorized by the U.S. Code. Fourth, how can CDC allocate funds given a proposed increase of

$56 million on safe motherhood and infant health in DRH and a separate item on IPV for the Injury Center in the Fiscal Year 2024 budget? Five, link informative interview to improve case ascertainment to address early warning signs, such as IPV, firearm protective orders? Six, design community-based injury-related maternal early warning systems to strengthen current early warning systems in clinic settings and reduce maternal morbidity and mortality. In summary, we have observed a 20-year gap in implementing authorized activities in the intersection of violence and maternal mortality at the CDC and the states. We advocate for data integration and a coordinated response through 6 items and request the BSC members, the Injury Center, attendees today to consider Dr. Elizabeth Fitelson and another colleague, Dorothy Cilento, and discuss the comment where one presented her perspective and hopefully the other one can join.

Jim Nowicki
Booz Allen Hamilton

Thank you. I'm Jim Nowicki. I'm with Booz Allen Hamilton. I have had the privilege of supporting the CDC for almost 20 years in a variety of roles. I just wanted to add a thought to—I think it was Dr. Caine who had brought up the idea of measuring the impact of all of the different programs and the really good work that is being done by Injury and all areas of CDC. My thought is that there is a lot of activity going on with what they call "data modernization" and all of that, and I believe that is going to enable more and more higher quality and more timely data coming in. I think it might be good if the Board of Scientific Counselors—maybe there is a workgroup to explore how CDC can take advantage of these newer and more up to date sources of data to measure impact across a variety of programs. That's my comment. Thank you for all the great work you are doing.

Chad Sniffen
Senior Technical Safety Specialist
National Network to End Domestic Violence

Hello. I'm Chad Sniffen. I'm a Senior Technology Safety Specialist with the National Network to End Domestic Violence Safety Net Project. We focus on the intersection of abuse and technology-facilitated gender-based violence. I didn't plan on making any comments, so this might be a little rough. The comment on assessing the prevalence of technology-facilitated gender-based violence and who is responding to that violence—the vast amount of response to the occurrence of gender-based violence online facilitated by technology are the platforms themselves. The platforms themselves have no common dictionary or lexicon for how to identify violence, so they have no common definitions to work from. They have no mandate for reporting. They have no mandate for sharing information. They are actually disincentivized to share information because of anti-trust regulations. There is a lot of information about how much teen-facilitated domestic violence is happening online or other forms of gender-based happening online that really, we don't have good ways to access or good ways even to quantify because of the lack of definitions. That's something that the Safety Project, who does a lot of consulting with corporations on their policies and practices that we often try to help them to address, but again, it's just one company at a time—whoever is interested in projects like that. Until we can access the platforms themselves or have some consistent communication with the platforms themselves, the prevalence of these experiences—we won't really know that. I just wanted to respond to a question at the beginning of this meeting about artificial intelligence and abuse. There is already a lot of documentation and I think the response to that—deep fakes were kind of the source of that abuse—and how generative AI is. There is lots of documentation and criminal information around deep fakes being kind of the main vector for that abuse in terms

of deep fake voice and deep fake pornography, especially among teens. That looks like basically teens making fake pornography of their peers and distributing them themselves. There also has been documentation in the popular media of that happening. That is a major form of abuse among teens right now in terms of technology abuse right now, and then deep fake voice in terms of faking people's voice for either scams or for threats and that looks like someone pretending to be your children—so deep faking the voice of a child and then calling their parents saying they are in jail, and they need money. That's kind of the scam version of that form of abuse, but there are other ways in which for various interpersonal reasons and really for more DV-related abuse, there's other ways in which that is happening as well. Thank you very much.

Dorothy Cilenti, DrPH
Clinical Professor, Gillings School of Global Public Health
Director, Maternal Health Learning and Innovation Center
Department of Maternal and Child Health
University of North Carolina Chapel Hill

Hi. This Dorothy Cilenti. I am at the University of North Carolina at Chapel Hill at the Gillings School of Global Public Health in the Department of Maternal and Child Health. I'm on the faculty there. One of my roles is to lead the Maternal Health Learning and Innovation Center MHLIC, which is funded through HRSA to support state grantees that are working to address maternal health disparities. My comment is really more a call to action. We believe that every birthing person deserves access to a community of care that is truly equitable where racial identity holds no influence over health outcomes, and that violence against pregnant individuals has negative impact throughout the entire perinatal period and intersects with the leading causes of pregnancy-associated deaths from homicides, suicides, and drug overdose. We believe that research and consequently innovations to combat these preventable deaths are needed and that we should focus on equity, training of providers, screening, universal education, and appropriate supports in the community. It is critical that healthcare providers and others who care for these pregnant individuals have access to research, training, and resources to better identify and refer all people experiencing violence before, during, and after pregnancy. By better identifying and subsequently preventing these cases of violence during pregnancy and during the post-partum period, there is the potential to positively impact the rate of severe maternal morbidity and maternal mortality. Thank you.

Closing Comments & Adjournment

Christopher Harper, PhD
NCIPC BSC DFO
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Harper thanked everyone for participating in the NCIPC BSC. He reminded all BSC members and *Ex Officios* to send an email to Mrs. Lindley stating that they participated in this meeting. He thanked all participants and members of the public for listening in and sharing their comments and extended special thanks to the presenters, the CDC Audio Technicians, Cambridge Communications, and On Par Productions. Of course, the meeting would not have been possible without Mrs. Tonia Lindley, Dr. Cory Ferdon, Mrs. Donna Polite, and Mr. Victor Cabada.

With no announcements made, further business raised, or questions/comments posed, **Dr. Harper** officially adjourned the Forty-Fourth meeting of the NCIPC BSC at 12:02 PM ET.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the January 11, 2024 NCIPC BSC meeting are accurate and complete:

Date

Christopher Harper, PhD
NCIPC BSC DFO

Attachment A: NCIPC BSC Roster

Designated Federal Official

Christopher Harper, PhD
NCIPC BSC DFO
Senior Epidemiologist, Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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Maury Nation, PhD
Professor of Human and Organizational Development
Peabody College
Vanderbilt University

Steve Ondersma, PhD
Clinical Psychologist and Professor
Division of Public Health and Department of Obstetrics, Gynecology, and Reproductive Biology
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CDC NCIPC Attendees

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Sandra Alexander, MS
Christopher Allen, RPh, MPH (CDR, USPHS)
Michelle Anaba, PH, CHES
Affie Asamte, MPH
Allison Arwady, MD, MPH
Sarah Bacon, PhD
Grant Baldwin, PhD, MPH
Mick Ballesteros, PhD
Megan Steele Baser, PhD
Kathleen Basile, PhD
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Tamara Blount, MA
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Corinne “Cory” Ferdon, PhD
Gwendolyn Fitch
Katie Forsberg, MPH
Molly Francis, PhD, MPH
Carlisha Gentles, PharmD, BCPS, CDCES
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Candice Girod, MPH
Carmen Goman, PhD
Marissa Goodson, RN, MPH
Naja Gunder
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Christopher Harper, PhD
Alexxus Harris
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Kristin Holland, PhD, MPH
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Robert Hood-Cree
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Shane Jack
Vardah Jamil, MPH
Ulaine Jean-Baptiste
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Starr Pena-Johnson, PhD
Emiko Petrosky, MD, MPH
Samuel Posner, PhD
Judith R. Qualters, PhD, MPH
Jaswinder K. Legha, MD, MPH
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Yanet Ruvalcaba
Katherine Sakai, PhD
Hanna Schurman
Monica Shaw
Joann Wu Shortt, PhD, MA
Carlos Siordia, PhD
Thomas Simon, PhD
Christine So, MPH
Andrea Strahan, PhD, MPP
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Sally Thigpen, MPA
Fred Thomas III, MPA, PCC, SPHR
Emmy Tran, PharmD, MPH
Emmanuel Fonseca Trujillo
Natasha Underwood, PhD, MPH
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Amy Wolkin, DrPh, MSPH
Mikel Walters, PhD
Jackie Watkins MPH
Ashley Watson, PhD, MPH
Cynthia White, PhD, MA
Aisha Wilkes, MPH
Christina D. Williams, PhD, MPH
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Allison Yatco, MSPH
Xin Yue, MPS, MS

Other Attendees
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Dorothy Cilenti, DrPH
Elizabeth Fitelson, MD
Trinse White Foster, PhD
Qing Li, MD, PhD
Claire G. Lisco, MA
Rita Nahta, PhD
James Nowicki, MBA

Chad Sniffen, MPH
Min Ji Suh
Alexander Tin
Stephanie Wallace, PhD
Kayleigh Zinter, PhD

Attachment B: Acronyms Used in This Document

Acronym	Expansion
ADS	Associate Director for Science
APHA	American Public Health Association
BSC	Board of Scientific Counselors
BU	Boston University
CCTI	Cambridge Communications and Training Institute
CDC	Centers for Disease Control and Prevention
CDPH	Chicago Department of Public Health
CIOs	Centers, Institutes, and Offices
CM	Child Maltreatment
COD	Cause of Death
COI	Conflict of Interest
DC	District of Columbia
DELTA	Domestic Violence Prevention Enhancement and Leadership Through Alliances
DFC	Drug-Free Communities Branch
DFO	Designated Federal Official
DIP	Division of Injury Prevention
DMI	Data Modernization Initiative
DOJ	Department of Justice
DOP	Division of Overdose Prevention
DRH	Division of Reproductive Health
DVP	Division of Violence Prevention
ED	Emergency Department
EIS	Epidemic Intelligence Service
EITC	Earned Income Tax Credit
ET	Eastern Time
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
FUTURES™	Futures Without Violence
FY	Fiscal Year
HHS	(Department) Health and Human Services
HRSA	Health Resources and Services Administration
IPV	Intimate Partner Violence
IOD	Immediate Office of the Director
JHU	Johns Hopkins University
IPV	Intimate Partner Violence
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning), Intersex, Asexual, and Others
MMRCs	Maternal Mortality Review Committees
MMWR	*Morbidity and Mortality Weekly Report*
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCIPC / Injury Center	National Center for Injury Prevention and Control
NICHD	National Institute of Child Health and Human Development
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health

Acronym	Expansion
NIJ	National Institute of Justice
NIMH	National Institute of Mental Health
NISVS	National Intimate Partner and Sexual Violence Survey
NNEDV	National Network to End Domestic Violence
NRCDV	National Resource Center on Domestic Violence
NVDRS	National Violent Death Reporting System Conference
NYC	New York City
OD2A	Overdose Data to Action
PREVAYL	Preventing Violence Affecting Young Lives
RPTS	Research Priority Tracking System
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SUD	Substance Use Disorder
SUDORS	State Unintentional Drug Overdose Reporting System
SV	Sexual Violence
TBI	Traumatic Brain Injury
UNC Charlotte	University of North Carolina Charlotte
US	United States
USF	University of South Florida
UTMB	University of Texas Medical Branch
WG	Workgroup
YRBS	Youth Risk Behavior Survey