

**U.S. Department of Health and Human Services
National Institutes of Health
59th Meeting of the
National Advisory Council on Minority Health and Health Disparities**

Virtual Meeting

February 4, 2022
11:00 a.m. – 5:00 p.m. EST

Meeting Minutes

Council Members Present

Eliseo J. Pérez-Stable, MD, Chairperson; Director, NIMHD
Emma Aguila, PhD, University of Southern California
Lisa L. Barnes, PhD, Rush University Medical Center
Esteban G. Burchard, MD, MPH, University of California at San Francisco
Neil S. Calman, MD, Icahn School of Medicine at Mount Sinai
Kimberly S. Johnson, MD, Duke University Medical Center
Keawe' Aimoku Kaholokula, PhD, University of Hawaii at Manoa
Brian Mustanski, PhD, MA, Northwestern University
Joan Y. Reede, MD, MS, MPH, MBA, Harvard Medical School
Kenneth A. Resnicow, PhD, University of Michigan
William M. Southerland, PhD, Howard University
Carmen Zorrilla, MD, University of Puerto Rico

Council Members Absent

Nitza Milagros Escalera, JD, MPA, City University of New York

Ad Hoc Members Present

Amy Elliott, PhD, University of South Dakota
Mario Sims, PhD, University of Mississippi Medical Center
Chau Trinh-Shevrin, DRPH, New York University School of Medicine

Ex Officio Members Present

Christine Hunter, PhD, Office of Behavioral & Social Sciences Research, NIH
Donald Shell, MD, MA, Office of the Assistant Secretary of Defense for Health Affairs

Representatives Present

Kimberly Allen, Executive Officer, Office of Administrative Management, NIMHD
Yujing Liu, PhD, Chief, Scientific Review Branch, Office of Extramural Research
Administration, NIMHD

Executive Secretary

Denise Russo, PhD, Office of Extramural Research Activities, NIMHD

Presenters

Michael Chiang, MD, National Eye Institute, NIH

Keawe' Aimoku Kaholokula, PhD, University of Hawaii at Manoa

Pebbles Fagan, PhD, MPH, University of Arkansas for Medical Sciences

Nancy Jones, PhD, Community Health and Population Sciences, NIMHD

Nathaniel Stinson, Jr., PhD, MD, Community Health and Population Sciences, NIMHD

CALL TO ORDER AND WELCOME

Dr. Eliseo Perez-Stable, Director of the National Institute on Minority Health and Health Disparities (NIMHD), called to order the Open Session of the 59th meeting of the National Advisory Council on Minority Health and Health Disparities (NACMHD) at 11:00 a.m.

ROLL CALL, MINUTES REVIEW

Dr. Russo called the roll. Council members and other present introduced themselves and their affiliations. The Council unanimously approved the minutes of the September 2021 Council meeting. Members were reminded of the future council meeting dates for 2022 and 2023 which appeared in the Meeting agenda, and that requirements allow for no more than one absence per calendar year. It was also stated that while serving on the Advisory Council, members cannot serve on any peer review panels.

NIMHD DIRECTOR'S REPORT AND DISCUSSION

Dr. Pérez-Stable provided the report on activities relevant to NIMHD since the September 2021 Council meeting.

GENERAL UPDATES

- Francis Collins, MD, PhD, announced his retirement as the National Institutes of Health (NIH) Director. He will continue to lead his research laboratory in the National Human Genome Research Institute (NHGRI). Dr. Collins served as NIH Director for 12 years and spanning three presidents, making him the longest serving director of NIH.
- Lawrence Tabak, DDS, PhD is now the Acting Director of NIH. Tara A. Schwetz, PhD has become the Acting Principal Deputy for NIH. Courtney F. Aclin, PhD, who previously was the NIMHD Chief of Staff, is now the Acting Associate Deputy Director.
- William T. Riley, PhD, has retired as the Associate Director for Behavioral and Social Science Research (OBSSR). Deputy Director Christine M. Hunter, PhD, ABPP will serve as the Acting NIH Associated Director for BSSR and Acting Director of the OBSSR. She is also an ad hoc member of the NIMHD Council.

- Carol Johnson has been appointed as the Department of Health and Human Services (DHHS) Administrator of the Health Services and Resource Administration. Most recently she serves as the Testing Coordinator for the White House COVID-19 Response Team. Previously, she served as the New Jersey Human Services Commissioner.
- A climate change and health initiative has been started at the NIH under the leadership of the National Institute of Environmental Health Sciences (NIEHS). Climate change will disproportionately affect the most underserved and vulnerable populations. There are many common elements in addressing structural health disparities as related to the climate change initiative. There is a need to develop more research infrastructure and a workforce capable of managing and leveraging partnerships across scientific and social disciplines as well as other governmental sectors. Innovative ways are needed to translate the research findings that are credible, accessible and actionable. NIH has posted a report summarizing the plans for this initiative. There is an ongoing portfolio analysis and a new seminar series entitled, "NIH Climate Change." NIMHD is hosting a seminar, *Why Climate Change is a Health Threat*, that will be held February 9th from 12-1PM. Registration is required, and the seminar is free and open to the public.
- NIMHD is collaborating with the Office of Data Science Strategy with \$1.6 million in supplemental funding that ODSS provided to NIMHD grantees through initiatives focusing on data infrastructure, data ecosystem, community engagement and workforce development.
- The NIMHD's [Health Disparities Research Institute](#) (HDRI) remains an ongoing program. The 2022 HDRI will be held August 15-19, 2022 and will be virtual. This is a week-long intensive and engaging training experience for promising early-stage investigators interested in minority health and health disparities research. Applications can be submitted beginning Monday, February 7th through Monday, March 14th. A total of 330 scholars have come through the HDRI with approximately 60% of participants representing underrepresented populations by race and/or ethnicity.
- The [Faculty Institutional Sustainable Recruitment for Transformation](#) (FIRST) common fund program has an estimated budget of \$241 million over nine years. The first cohort awardees are Cornell University, Drexel University, Florida State University, Icahn School of Medicine at Mount Sinai, San Diego State University, University of Alabama at Birmingham/Tuskegee University partnership. Morehouse School of Medicine was awarded the FIRST Coordination and Evaluation Center (CEC). NIMHD is managing the CEC and the National Cancer Institute (NCI) will manage the awardees. While the original plan was to fund four institutions each year, the IC Directors were able to provide additional funding and NIH is supporting six institutions. Two more rounds of funding are planned
- The [NIH Common Fund](#) has launched an initiative titled, Community Partnerships to Advance Science for Society (ComPASS) for more research focused on addressing structural factors to reduce health disparities through community-driven interventions. In fiscal year 2021, the Common Fund allocated funds to an initiative, which funded grants to six high resource institutions and five lesser resourced institutions. A small amount of

funds has been allocated for fiscal year 2022 but only for minority serving institutions. Recently, the Council of Councils approved a concept to develop a transformative initiative for addressing health disparities that will hopefully begin in fiscal year 2023. The goal of ComPASS is to invest approximately \$400 million over 10 years, centering primarily on funding community organizations to develop and implement interventions to address structural factors, a coordinating center and research hubs.

LEGISLATIVE UPDATES

- On October 22, 2021, Anna Nápoles, PhD, NIMHD Scientific Director participated in a NIMHD and NCI Program Staff Briefing for the Coronavirus Crisis Select Committee Staff on Disparities in Excess Deaths Study.
- On October 27, 2021, Dr. Pérez-Stable participated with the Frances Collins, PHD, NIH Director, Diana Bianchi, MD, NICHD Director, and Shannon Zenk, PhD, MPH, RN, FAAN, NINR Director at a briefing for the Congressional Nursing Caucus on the Impact of Nursing Research.
- On December 9, 2021, Monica Webb Hooper, PhD, NIMHD Deputy Director, participated in a briefing for Representative Bonnie Watson Coleman's (D-NJ) staff on health disparities research and mental health.
- On December 15, 2021, Monica Webb Hopper, PhD, NIMHD Deputy Director participated in a joint briefing with Shelli Avenevoli, PhD, NIMH Deputy Director for the Senate HELP Committee staff on mental health and related health disparities.

BUDGET

- Dr. Pérez-Stable presented an overview of the NIMHD budget between fiscal year 2016 and fiscal year 2020. The growth of the budget was primarily driven by two factors: (1) enhanced increases in the set asides for the Research Centers and Minority Institutions program (RCMI) and (2) generalized increases that NIH received. While most of these increases were already allocated for set asides, there were residual funds which allowed the NIMHD to fund more programs and grants. In fiscal year 2021, the budget growth was largely due to another amount that had been set aside for the Multiple Chronic Disease Research Centers (MCDRC), which totaled 45 million dollars, that was added to NIMHD's base budget.
- The proposed budget for fiscal year 2022, which was still awaiting congressional approval, was approximately \$651 million. The Presidential, Senate, and House proposals were all suggesting a similar amount for the NIMHD budget.
- In fiscal year 2021, about 40% of the NIMHD budget was used to fund research grants, approximately 90% of which was for R01s or equivalent. About 20% of the budget went to RCMI and roughly 17% went to other research centers including Centers of Excellence, Environmental Health Disparities Centers and the MCDRCs. The percentage of the budget that these areas would use in the future was not expected to change but the monetary amounts would increase. Contracts and operating expenses constituted most of

the remaining budget along with the legislated amounts allocated to Small Business Innovative Research (SBIR) and Small Business Technology Transfer (STTR). The K Awards, loan repayment program and others were budgeted under other programs and training.

- The R01 success rate for fiscal year 2021 was 12.9%, which is an improvement compared to prior years and would hopefully continue to increase. Across the NIH, the average success rate for fiscal year 2021 was 19.5%. NIMHD did not fund grants in the order scored, as some grants that scored in the 30s were funded. This was done through a select pay approach to emphasize our institute priorities. If the planned budget increase moves forward, the NIMHD plans to increase the budget for K awards and SBIR/STTR programs.
- The loan repayment program continued to have a large emphasis on success, allowing for more individuals to join the research field. Approximately 60% of the program's awardees came from underrepresented groups, and the program success rate has grown from around 16%, in prior years, to 30% in fiscal year 2021. The increase was due to fewer applicants because of a change in the rules that allowed for loan repayment applicants who were interested in health disparities to apply to other ICs within the NIH.
- The NIMHD continues to support and collaborate with the Office of AIDS Research (OAR), to address issues regarding the End the HIV Epidemic initiative using R01s and other opportunities through supplemental awards to institutions, particularly in RCMI communities.
- Entering the third year of the COVID-19 pandemic, the NIH had an incredible response to COVID, but understandably there was fatigue amongst the community. Regardless, staff and researchers across the NIH continue to work diligently. NIMHD has been engaged since the beginning of the pandemic with involvement in major NIH initiatives.
- Other fiscal year 2021 funding accomplishments include a 27% increase in funding for training awards (Ks and Fs), continued support to MACS/WIHS Cohort study and CFARS program in NIAID, and the Adelante program support, support for Community Interventions to Address the Consequences of the COVID-19 Pandemic, and Vaccine Hesitancy R01s.

NIMHD UPDATES

STAFF UPDATES

- Rina Das, Ph.D. has been selected as the Director of the NIMHD Program Division of Integrative Biological and Behavioral Sciences. She has led a wide array of initiatives including social epigenomics, sleep health disparities, and immigrant health. Before joining NIMHD in 2014, Dr. Das served as a program director at the NCI Center to Reduce Cancer Health Disparities.
- Crystal Barksdale, Ph.D., MPH and Jarret Johnson, DrPH, MS, CHES have joined the NIMHD Program Division of Community Health and Population science.

- The NIMHD Division of Clinical and Health Services Research welcomed new staff members Michelle Doose, PhD, MPH, Yewande A. Oladeinde, PhD, Carolina Solis Sanabria, MD, and Sundonia J. Wonnum PhD, BCD, LCSW.
- The NIMHD Division of Integrative Biological and Behavioral Sciences welcomed new staff members Arielle Gillman, PhD, MPH and Olga Herren, PHD. Dr. Gillman and Dr. Herren both completed their cancer prevention fellowship.
- Gniesha Dinwiddie, PhD joined the Office of the Director, assisting Dr. Pérez-Stable and Dr. Webb Hooper in reconfiguring operations on the expansion of the office's science capacity to manage and lead programs cutting across the entirety of the NIMHD.
- Jingsheng Tuo, PHD joined the Office of Extramural Research Activities in the Review Branch.
- Assen Assenov, PHD has transitioned from a contractor to a federal employee as a health economist in the Office of Science Policy Planning Evaluation and Reporting (OSPPEP).
- Thoko Kachipande, MS and Melanie Santos, MPA have joined the Office of Communications and Public Liaison.
- Jeanne Jones officially joined the Office of Administrative Management as a management analyst.
- Thomas M. Vollberg, Sr., PhD retired as the, Director of the Office of Extramural Research Activities (OERA) and Executive Secretary for the Council. Dr. Vollberg came to NIMHD from NCI as the Director of Review. Monica Webb Hooper, PhD is the acting Director until a new director is brought onboard. Denise Russo, PhD was on detail and served as the Executive Secretary to the Council.
- Natasha Williams, PhD, JD, LLM, MPH has departed NIMHD and promoted in the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Dr. Williams served as the NIMHD Legislative Liaison in OSPPEP.
- Commander Nadra Tyus, DrPh, a program officer in the DIBBS, has transferred to the Officer of the Director, Office of Strategic Coordination in the Common Fund. She will continue to support the FIRST CEC and work with NIMHD on the Transformative Common Fund Disparities Initiative. Dr. Tyus was instrumental in the management of the RCMI program.
- Matt Wise, the NIMHD Senior Information Technology Officer has taken on a new position with the Center for Scientific Review. NIMHD is recruiting for a Chief Information Officer.
- Dr. Perez-Stable reported on several virtual presentation interviews and blog posts. A few are listed below: visits to NIH.
 - Presentation: US Public Health Service Hispanic Heritage Month Webinar
 - Interview: National Coalition of 100 Black Women Inc. Facebook Live
 - Interview: [Bringing Diversity to COVID-19 Vaccine Trials - Bloomberg](#)
 - Interview: Washington Post Live
 - Presentation: Congressional Hispanic Caucus Institute 2021 Fall Health Summit
 - Blog Post: [NIMHD Lauds New Awards on Innovative Health Disparities and Health Equity Research](#)

- Blog Post: [Heartfelt Thanks to the NIMHD Scientific Community in the Time of COVID-19](#)
- Dr. Perez-Stable met with the Secretary of DHHS, Xavier Becerra during his visit to the NIH campus. He discussed the mission and programs of NIMHD.
- The CEAL Spanish Language Media reaches approximately 15 million viewers. Dr. Perez-Stable participated in the Telemundo's Morning Show, Hoy Dia. He discussed the Omicron variant, the efficacy of the vaccines against the new variant and how important it is for as many people to get vaccinated and boosted. He also appears on the Univision Morning Show: La Voz del la Manana where he discussed Omicron, the symptoms that people can experience and their concerns and fears. Additionally, Dr. Perez-Stable appeared on the Univision National Nightly News, Despierta America, Univision Houston, and Univision Prende TV.
- NIMHD awarded research grants to Multiple Chronic Disease (MCD) Centers focused on chronic diseases that disproportionately affect population with health disparities. Eleven grant awards were made totaling approximately 205 million dollars. The MCD Centers will address interventions in cardiovascular, diabetes, obesity, chronic liver disease, chronic kidney disease, cancer and osteoarthritis; prevention of chronic diseases by addressing risk factors and early stages of a condition; increasing access to and quality of health care; enhancement of treatment quality or adherence, and self-management of chronic diseases. MCD's affects the quality of life for all older adults especially and disproportionately affects working people. NIMHD would like to see more research and results from MCD Centers not just on clinical outcomes but on equity in access to quality health care.

SCIENTIFIC ADVANCES

- The study, [Childhood Maltreatment Exposure and Low-Grade Inflammation: Evidence of Sex Differences](#) found that are links between maltreatment during childhood and low-grade inflammation in adulthood. Researchers examined 155 children from low-income families of which half were exposed to maltreatment. The inflammation composite of C-reactive proteins and cytokine levels were measured. Girls who were maltreated had higher levels of inflammation than girls who were not maltreated and girls who were exposed to two or more forms of maltreatment had higher inflammation that girls who were not maltreated. This has brought more awareness to the science community on how important abuse, maltreatment, and harassment is in the life course. (Erlich, K. et. al., Dev Psychobiol, 2021)
- [COVID-19 Vaccine Hesitancy in Underserved Communities of North Carolina](#) is a survey of 948 participants (59% African Americans, 27% White and 14 Latino/a) at over 30 COVID-19 testing events in testing deserts in North Carolina between August and December 2020. Between September and December 2020, the largest percentage point decline in vaccine hesitancy occurred among Whites (27.5), followed by Latinos (17.6), and African Americans (12). Factors associated with hesitancy included women being

African American, the different calendar months, safety concerns, and government distrust. (Doherty, I., et. al, Plos One. 2021)

- The MADRES Cohort, one of NIMHD's Environmental Disparities Research Centers, looked at the relationship between daily prenatal exposure to ambient pollutants across pregnancy (nitrogen dioxide NO₂, ozone O₃, and particulate matter PM₁₀ PM_{2.5}) and depression among low-income Latina (mostly Mexican American) women in Los Angeles, California. [Prenatal Ambient Air Pollution and Maternal Depression in MADRES Cohort](#) is the first study investigating the effects of multiple prenatal ambient pollutants on maternal depression using daily estimates of ambient air pollutant exposures while accounting for residential mobility. The study noted that depression increased with the second trimester NO₂ exposure. Higher second trimester PM_{2.5} exposure was also associated with increased depression. It is known that particulate matter much of it from combustion is bad for the lungs and heart and may also contribute to potential development of cancer, mental health issues and depression. (Bastain, T., et.al., Environ Health. 2021)
- Another study examined the [relationship between dietary quality, food insecurity, and glycemic control among adults with Type 2 diabetes](#). The researchers collected data from the National Health and Nutrition Examination Survey (NHANES) between 2011-2016 for 1,682 adults 20 years and older. The study noted that poor glycemic control among adults with diabetes was associated with poor quality of diet and food insecurity, being African American and/or Latino and lacking a regular source of health care. Experiencing food insecurity is a major contributor in diabetes control of working people. It is estimated that ten percent of the US population has some level of food insecurity; estimates are higher (~20 percent) for African Americans and Latinos depending on age. Food insecurity often leads to greater consumption of caloric dense foods and excess weight gain. (Shaheen, M. et. al., Clin Nutr ESPEN. 2021)
- A [New Protocol for Development of EHR/CDS to Provide Social Risk Informed Care](#) is a product of the Health Information Technology and Health Disparities Initiative. Little is known about the adoption and impact of social risk – informed care for reducing disparities in care outcomes. The proposed study by Rachel Gold and her team will be the first study to develop and test electronic health records (EHR) -based clinical decision support (CDS) tools that present care teams with patients' social risk information to both recommend and facilitate care plan adaptations based on those social risks resulting in improved health outcomes. The study will be conducted among Clinical Health Centers (CHCs) that are member of OCHIN, a nonprofit health center-controlled network that hosts the same Epic EHR for more than 600 CHCs located in the US. To carry out this hypothesis, intervention clinics will be followed for 18 months to assess CDS tool adoption, actions taken by care team, and impact on national clinical quality measures: BP and HbA1c. The findings may inform strategies that can ensure social risk screening initiatives translate to improvements in care and health outcomes. Many professional organizations such as the American College of Physicians for evidence-based practices for utilizing EHRs to screen for social determinants of health (SDoH) and to make sure of

the information in an actionable way to improve health outcomes for vulnerable populations. (Gold, R., et. al., JMIR Protoc. 2021)

- The paper, [Association of the ACA Medicaid Expansion with Trauma Outcomes and Access to Rehabilitation among Young Adults](#), discussed the impact of the ACA Medicaid expansion on trauma care in statewide hospital discharge data from five states that did and five states that did not expand Medicaid from 2011-2013 and after 2014-2017. Medicaid expansion was associated with a decrease in uninsured patients. The decrease was larger for African American patients but smaller among Latino than White patients. Latinos in general have the highest rates of uninsured in the US. The decrease was larger among patients from lower income ZIP codes. The study also found an increase in discharge to inpatient rehabilitation especially among patients from the lowest-compared with highest-income ZIP codes. There was also a decrease in in-hospital mortality among African American patients. For young adults experiencing trauma, ACA expansion significantly increased hospital length of stay and access to facility-based rehabilitation care but not home healthcare. (Metzger. G., et. al., J Am Coll Surg. 2021)
- [Racial and Ethnic Disparities in Excess Deaths During COVID-19](#) is a study that looked at provisional death certificate data from the CDC and population estimates from the Census to compare excess deaths by race/ethnicity, sex and age groups between March and December 2020. It is difficult to quantify the cause of death due to COVID-19 in relation to the excess cardiovascular or cancer deaths that would be the expected highest number. Approximately 2.9 million people died in the US between March and December 2020. About 477,200 excess deaths compared to 2019 with 74% attributed to COVID-19. Excess deaths per 100,000 persons among African American, American Indian/Alaskan Native, and Latino men and women were two to three times higher than White and Asian men and women. Additionally, excess deaths due to non-COVID-19 causes were three to four times higher among African American and American Indian/Alaska Native men and women and two times higher in Latino men and women compared with White men and women. (Shiels, M., et. al., Annals of Internal Medicine. 2021)
- Dr. Pérez-Stable NHLBI laboratory study, [Stress, Unhealthy Behaviors, and Depression in the Hispanic Community Health Study/Study of Latinos \(HCHS/SOL\)](#) reported on 11,613 individuals from the HCHS/SOL evaluated at two visits (2008-2011 and 2014-2017) for allostatic load (12 biomarkers for physiological stress), depressive symptoms (CES-D 10), perceived chronic stress, and unhealthy behaviors (i.e., cigarette smoking, excessive/binge drinking, sedentary lifestyle, and poor diet. This study was in part prompted by a hypothesis that some populations built their resilience to the stress of unemployment or being poor or other issues in their community by behaviors such as unhealthy eating, use of substances or smoking. Dr. Perez-Stable's team found that higher allostatic load was associated with higher odds of elevated depressive symptoms after at least six years. They also found that those with high allostatic load and one unhealthy behavior compared to those with no unhealthy behaviors, had lower odds of depressive symptoms. The study concluded that identified and modifiable behaviors influenced how physiological stress affects depression among Hispanics/Latinos but

showed limited potential to assessing these relationships in specific heritages. (Rodriquez, E.J., et. al., SSM-Populations Health. 2021)

- An NIMHD Division of Intramural Research study, [COVID-Related Discrimination in Racial/Ethnic Minority Communities and Marginalized Communities in the US](#) is a nationally representative online survey of 5,550 US adults that was conducted between December 2020 and February 2021. The study highlights 1) the high prevalence of COVID-related discrimination, and 2) COVID-19 may have exacerbated pre-existing resentment against marginalized communities. The sample was comprised of Asians, African Americans, Latinos – half Spanish-speaking – American Indian/Alaska Native, Hawaiian/Pacific Islander, and multiracial adults. The study found that all adults belonging to racial/ethnic minority populations were more likely to experience discrimination compared to White adults. Asian Americans and American Indian/Alaska Natives adults were most likely to experience discrimination. Limited English proficiency (LEP), lower education, lower income, and living in large city or Southeast Center division was also associated with increased discrimination. (Strassle, P.D., et. al., AJPH in press)
- [Access to Pharmacies and Pharmacy Services in NYC, LA, Chicago, and Houston, 2015-2020](#) is a publication from Dr. Shannon Zenk, the Director of NINR's lab in the NIMHD Intramural Division of Research. Her group evaluated trends and disparities in access to pharmacies by neighborhood composition. This is a secondary analysis of data from the National Council for Prescription Drug Programs (2015-2020) and the American Community Survey (2015-2020). The pharmacy deserts were persistently more common in African American and Latino neighborhoods in all four cities. As of 2020, pharmacies in African American and Latino neighborhoods were also more likely to close and less likely to offer immunization, 24-hour and drive-through serves than pharmacies in other neighborhoods. The study showed that persistent and worsening racial and ethnic disparities in access to life-saving neighborhood resources were essential for a COVID-19 response. (Guadamuz, J., Zenk, S., et. al. JAPhA. 2021).
- The [Health Disparities Interest Group](#) at the NIH was reactivated under the leadership of the NIMHD's Intramural Division. In 2021, there were two presentations. Dr. Nicholas Jones presented on Racial and Ethnic Diversity in the United States: Highlights from the 2020 Census. Dr. Margarita Alegria, a former Council member, presented on *The Role of Feasible and Sustainable Intervention in Reducing Health Disparities*.
- Allana T. Forde, PhD, MPH, a Stadtman Tenure-Track Investigator and NIH Distinguished Scholar in the NIMHD Division of Intramural Research received the Journal of Hypertension Award for her paper on *Discrimination and Hypertension Risk Among African Americans in the Jackson Heart Study*. She was selected as the top paper for 2020 in the category of population science.
- Kelvin Choi, PhD who is the first NIMHD promoted tenured senior investigator, gave a presentation at the NIH Director's Seminar Series titled, *The perfect storm: Intersections of social determinants of health, commercial determinants of health, and commercial tobacco use disparities*. His presentation focused on the interrelationships between SDoHs and commercial tobacco use, the role of commercial determinants of health on

commercial tobaccos use disparities and interventions to reduce commercial tobacco use and related health disparities.

- The [NIMHD Director Seminar Series](#) will host four presenters in 2022. Joan Y. Reede, MD, MS, MPH, MBA from Harvard University Medical presented in February. Mark Hayward, PhD a sociologist and demographer from the University of Texas Austin will present in May, Hortensia Amaro, PhD from Florida International University has done work on behavioral research on substance use in populations with health disparities, will present in September and Judith A James, MD, PhD, a clinical scientist who has worked with translational research in rheumatological diseases with American Indian Health from the Oklahoma Medical Research Foundation will present in November,.
- The [UNITE Initiative](#): Power of an Inclusive Workplace Recognition Project highlights the diversity of NIH staff and reflect the diversity of our nation in order to promote a sense of inclusivity and belonging. The project focuses on diversifying art within NIH buildings and digital spaces. *Together we're Stronger* features Sherine El-Toukhy, PhD, MA, an NIMHD Division of Intramural Research Stadtman Tenure-Track Investigator and NIH Distinguished Scholar.

PRESENTATIONS

National Eye Institute: What We Do and What We Might Do With NIMHD Michael Chiang, MD, Director, National Eye Institute

Dr. Chiang summarized his educational background and the path that had led him to become an ophthalmologist with an interest in biomedical informatics and electronic management of medical records. Dr. Chiang worked extensively on a national electronic registry of eye exams, which became one of the largest collections of specialty specific data in the world. He discussed the importance of eye health and its role in mental health, explaining that blindness was one of the largest fears for the U.S. population, and that inability to see properly often led to depression, anxiety, and other mental health issues. While these issues were not specific to any one population group, the disparity in access to optical health providers among different minority groups was very evident.

As the new NEI Director, Dr. Chiang engaged internal and external stakeholders to revise the mission statement: "The mission of the NEI is to eliminate vision loss and improve quality of life through vision research". This is done by providing leadership in (1) driving innovative research, (2) fostering collaboration, (3) strengthening the vision workforce by recruiting, inspiring, and training a talented and diverse new generation of researchers and practitioners, and (4) educating the public on what the NEI does and why the Institute's work is so important.

Dr. Chiang continued his presentation on eye disease disparities in minoritized populations and the disparity in access to vision care. He stated that glaucoma is one of the leading causes of blindness in the world, is diagnosed at a rate four to five times higher among

African American populations than among White populations, and a higher rate among minoritized populations in general. There is not a complete understanding why this occurs but it is felt that accessibility and genetics may play a part. Glaucoma is a treatable and manageable disease for example eye drops, laser procedures and surgeries. However, the issue was getting people to seek care and making sure that the care was accessible. Diabetic retinopathy which if not monitored or treated, could lead to blindness. Akin to glaucoma, there are treatment methods to prevent blindness such as laser therapy and injections in the eye, but the issue is the rate of screening, the higher rate of occurrence among minoritized populations and difficulty identifying and manage patients. Youth from minoritized populations were 40% less likely to get diabetic eye exams and five times more likely to develop diabetic retinopathy than White youths.

Myopia and other refractive errors which could be resolved with glasses, were also issues that faced minoritized populations more than Whites due to the lack of access to vision care and higher rates of occurrence. Without early diagnoses, these issues can impact development of the vision system, learning and disproportionately impacts minoritized youth. Compared to White youth, African American youth are at six times the risk, and Hispanics are at three times the risk for myopia and nearsightedness.

Cataract is the number one most common procedure done in ambulatory surgery centers in the U.S. Minoritized populations are more likely to have visual loss from unoperated cataract perhaps due to lack of access. The Baltimore Eye Survey found that African Americans and Latinos were five times more likely to have unoperated cataracts. Vision loss and blindness are one of the leading causes of disability in the U.S.

Dr. Chiang discussed advancements in imagery and electronic records and what the implications of those advances were for the broader field of research and studies. He highlighted how optical coherence tomography (OCT) has opened enormous opportunities in data science and artificial intelligence (AI) by providing objective quantitative data to support other research studies. Dr. Chiang discussed how ophthalmology is a primary field leading the development of artificial intelligence (AI) methods for medicine. This was due to images and structured data from electronic health records (EHR). One example was Google that developed an AI using datasets of hundreds of thousands of retinal images to assess systemic health. The AI could not only determine an individuals' age, but also sex. Some of the first successful genome-wide association studies (GWAS) were for age-related macular degeneration. As well, the first FDA approved gene therapy for an inherited disease in any field of medicine was in vision.

Dr. Chiang's then discussed the NEI's future and what the NEI and the NIMHD could collaborate on moving forward. The new NEI strategic plan has seven cross-cutting areas of focus: genetics, neuroscience, immunology, regenerative medicine, data science, quality of life, and public health and disparities. Anecdotes of what methods could be used to address these areas included the use of telemedicine in ophthalmology, the development of practices

and standards within telehealth, and studies on social determinants and why people lose their vision from treatable diseases rather than seeking care. Another area under development using AI to analyze and study large heterogeneous datasets and detect bias in EHRs as opposed to current AIs that were developed in academic settings with small homogeneous datasets and could not handle datasets with inputs from multiple ethnic and racial backgrounds. Many of these ideas returned to the concept of developing more cross-study collaborations with standardized data representations so as to promote data science and data sharing.

In closing, Dr. Chiang reiterated potential areas for collaboration with NIMHD such as the delivering eye care to underserved populations through technology, siting and improving health equity through objective image data, artificial intelligence, data sharing, and accessibility by visually impaired people. Additionally, strengthening the vision workforce in areas like social determinants of health and health equity.

Achieving Health Equity for Native Hawaiians and Pacific Islanders

Keawe' Aimoku Kaholokula, PhD, Professor and Chair of Native Hawaiian Health Co-Director for the PILI 'Ohana Community- Academic Partnership, John A. Burns School of Medicine, University of Hawai'i at Mānoa

Dr. Keawe' Kaholokula, began his presentation by discussing how in the past population data on Native Hawaiians and Pacific Islanders (NHPI) had been aggregated with Asian populations. Since the 2000 Census, the Office of Management and Budget (OMB) has recognized NHPI as a distinct racial/ethnic group. The 2020 census shows that the population of NHPIs in the U.S. has grown 31% since the 2010 census noting that 0.5% of the U.S. population identifies as NHPI including those of more than one race. Among NHPI 43% identified as Native Hawaiians, and models showed a projected growth that would double the population over the course of the next few decades. NHPI uphold their cultural values and practices around family and community cohesion and interdependence, ancestral fidelity, maintaining harmony with nature and those around them, and maintaining spiritual and religious convictions. They strive to maintain a strong cultural identity and connection to island homes and ancestral lands.

Dr. Kaholokula moved onto the focus of his presentation, health disparities between NHPI and Whites. NHPI, on average, developed chronic diseases 10 years younger than other race/ethnic groups as well as having life expectancies 10 years shorter. The rate of NHPI that had three or more chronic diseases was 22% compared to 10% among non-Hispanic Whites. In the Native Hawaiian population 75% of adults reported one or more adverse childhood experiences, which on average was greater than any other ethnic group. Native Hawaiians had an uninsured/under-insured rate of 30%, with 15% of Native Hawaiians living in extreme poverty.

Dr. Kaholokula discussed the impact that acculturation had on the rate of diabetes among Native Hawaiians. Trends showed that individuals with a higher association to native culture and less interest in integration had a higher risk of diabetes while those who integrated with less interest in traditional culture had a lower risk, with an overall rate of 19.2% of Native Hawaiians living with diabetes. This study, ([Kaholokula, et.al Association between acculturation modes and Type 2 Diabetes in Native Hawaiians Diabetes Care, 2008, 31, 698-700](#)) included a sample of 495 Native Hawaiians taking into account the age, education, degree of Hawaiian ancestry, and level of triglycerides as markers of poor diet. The study found that there were large differences in diabetes risk that were not based on biological or genetic factors, and differences in psychosocial stressors associated with cultural identify and/or affiliation. and higher reports of experiencing racism among Native Hawaiians with stronger Native Hawaiian identity.

Dr. Kaholokula discussed how the health disparities among Native Hawaiians is associated more with social and cultural determinants of health rather than genetics. Those who identified as traditional Native Hawaiians experienced a higher rate of interpersonal racism than those who lived more integrated lifestyles. Individuals, who had experienced more racism in their lifetimes, resulting in chronic stress, produced lower levels of cortisol. They also ran a higher risk of hypertension, high blood pressure, obesity and psychological distress. He also pointed out that subtle racial stressors, as opposed to blatant racial stressors, led to greater long-term stress among individuals in the Native Hawaiian community.

Another finding was a higher rate of distrust among Native Hawaiians towards western institutions of medicine and science caused by historical transgressions, which the COVID-19 pandemic had exacerbated, specifically distrust of COVID-19 vaccines. The study found that a key determinant of health among NHPs was a history of trauma and disadvantage with the U.S. government. This led to distrust continuing to affect individuals with more traditional lifestyles compared to individuals with integrated lifestyles. Additionally, environmental factors such as availability of fast food, lack of access to fresh produce, exposure to industrial toxins and less exercise has led to a more obesogenic community amongst NHPs. Other impacts included food insecurity, lack of liberal wages, inadequate education, and low health care access.

Dr. Kaholokula then focused on how to address those health disparities while maintaining and utilizing Native Hawaiian culture. The 11-year Partnership for Improving Lifestyle Intervention (PILI) 'Ohana was established through the NIMHD Community-Based Participatory Research (CBPR) program. The [PILI 'Ohana](#) project focused on obesity and related disparities. This program included a partnership with five CBOs, the development of three culturally informed interventions, and dissemination to over 30 CBOs across Hawaii and NHP communities in California and Arkansas. The interventions adapted a condensed Diabetes Prevention Program (DPP), a family lifestyle program, a DSME (Partners in Care) program, and a Worksite Lifestyle program. This was a randomized study where half of the

participants received family and community interventions and half received standard behavioral interventions via phone calls to review their weight loss plans. One lesson learned was that communities felt a condensed course on diabetes prevention focusing more on family and community would be more conducive for their culture and lifestyle. The program resulted in modest weight loss, significant decrease in blood pressure with marked improvements in physical functioning and walk tests over three months. Also, it appeared internalized focus (psycho-social factor) best predicted weight loss. The results of this randomized clinical trial demonstrated that 51% of participants in the treatment group achieved a greater than three percent total body weight loss, compared to 31.4% of participants who achieved the same result in the control group. A more significant finding was the greater reduction in blood pressure amongst the treatment group as opposed to the control group. The study found that those who lost more weight in the first three months were better predictors of long-term weight loss and maintenance compared to those who did not lose a significant amount of weight in the same time frame based on other generalized studies on weight loss. It was determined that different groups of NHPs had higher acuties towards the weight loss interventions than others.

This finding led to the development of more cultural community-based intervention programs, rather than adapting successful programs in mainstream communities. [Ola Hua I Hula program \(HULA\)](#) was created as a study to reach different NHP communities and their differing cultural backgrounds while addressing issues of hypertension and cardiovascular disease (CVD). They found that an active hula class reached an equivalent level of exercise as ballroom dancing, playing tennis, basketball or volleyball depending on the level of intensity. The Hula program included lessons on hypertension management, prescription comprehension, medical communication, and stress management. The goal of the Hula study was to find trends for future research. However, significant differences were found in the treatment group as opposed to the control group. 72% of the intervention group's systolic blood pressure dropped by 10 points or more compared to 39% in the control group. Conclusions from this study showed that improvements in blood pressure were associated with improvements in social functioning, decreases in bodily pain and decreases in perceptions of racism compared to the control group that had no measurable change. Dr. Kaholokula stated that while traditional western forms of weight loss can have great results, culturally based interventions could result in greater socio-cultural outcomes in health, where other approaches have not proven to be as successful. The study followed both groups for six months, three months of which were without intervention; finding that blood pressure returned to the baseline metrics. In response they studied how to make the Hula program an indispensable part of the participants' lives to encourage continued participation and maintain weight loss. A portion of the program named, Ma Ka Hana Ka 'Ike meaning "by doing, one learns", involved extending the program three months, integrating self-regulation theory, applying the program to participants' daily lives.

A second study was funded by the National Heart Lung and Blood Institute (NHLBI) for a more extensive review of the health benefits of HULA program but with one different

sampling criteria: participants were required to have uncontrolled hypertension at baseline measures while not having heart disease and indications of stroke or CVD. In this 12-month study, participants in both control groups received four weeks of heart health and blood pressure management lessons. All participants were diagnosed at stage two of hypertension as a prerequisite, but 43% of the Hula group was able to get their blood pressure below 130/80, with only 21% of the control group able to achieve the same. Using the Framingham risk scores, risk of CVD development in the HULA group reduced by two-fold, compared the control group, in a ten-year timeframe.

Dr. Kaholokula discussed several workforce diversity initiatives that were funded by NIMHD specifically, the Minority Health Research Training (MHRT) program, through which 16 Native Hawaiians received training, education and travelled to New Zealand to work with the University of Auckland on studying indigenous Maori communities and other Pacific Islanders. Other programs include, the [Ola HAWAI'I](#) (Health/Heal and Health and Wellness Achieved by Impacting Inequalities), a RCMI Specialized Research Center that supports multidisciplinary teams of investigators and community collaborators to conduct basic biomedical, behavioral and clinical research on the causes of health disparities and effective solutions to reduce those disparities among the underserved, multiethnic populations in Hawai'i, and the Center for Pacific Innovations, Knowledge, and Opportunities ([PIKO](#)) and Institutional Development Award Networks for Clinical and Translational Research (IDeA-CTR) with the goal to improve the health of Indigenous Pacific Peoples and other medically underserved populations by fostering the development and facilitating innovative and evidence-based clinical and translational research.

Dr. Kaholokula concluded his presentation discussing the current challenges facing NHPI communities. For example, the lack of NIH-funded studies focused on NHPI, continued aggregation of NHPI data with Asian population data, lack of federal agencies including and consulting with NHPI leaders and organizations, lack of NHPI representation in clinical trials and research, and in education where many NHPI faculty and potential researchers do not have a clear career path in the health sciences.

Saving Our Communities: The Role of Community and Policy Interventions
Pebbles Fagan, PhD, MPH, Professor and Director Center for the Study of Tobacco,
College of Public Health, Director of Research, Office of Health Initiatives and
Disparities Research, University of Arkansas for Medical Sciences

Dr. Pebbles Fagan, professor, and Director of the Center for the Study of Tobacco at the Faye Boozman College of Public Health in Arkansas, presented on several areas including the contextual factors that influenced how rural communities accessed evidence-based interventions, specifically related to tobacco use and exposure to COVID-19. Dr. Fagan presented information on studies that looked at the impact that community organizations, such as churches and sororities had on tobacco usage, as well as where people live, work and play. In rural communities in the Delta, unemployment rates were higher while the

physical activity rates were lower than in urban areas. Also, the rates of secondhand smoke exposure and lung cancer were higher than the national average among African Americans in Arkansas.

[Families Rising to Enforce Smoke-free Homes \(FRESH\)](#) is an ongoing randomized controlled behavioral intervention trial that aims to increase comprehensive smoke-free policies within the home as a primary outcome and quitting smoking as a secondary outcome. The sample population is comprised of African American women caregivers who are current cigarette and/or little cigar and cigarillo (LCC) smokers that reside in Lee and Phillips counties in the Delta region of rural Arkansas. These low resourced counties with a population of about 20,000 have twice the average national smoking prevalence with 23% - 26% heavy smokers.

Dr. Fagan discussed the reach of community and policy interventions to rural communities and the Elaine Massacre that occurred in Phillips County between 1819-1919. There is an underlying assumption that policies are an important strategy to protect disparate population from tobacco smoke exposure and smoking. Also, if there were ever a ban on menthol tobacco, which is most commonly used by African Americans, then perhaps disparities in smoking and exposure would be lower. However, federal policy change is needed and in Tobacco Nation states like Arkansas, state-level protective policies are decades away. Dr. Fagan discussed a 2006 research report that looked at workplace and home smoking restrictions and racial/ethnic variation in the prevalence and intensity of current cigarette smoking among women by poverty status. The report pointed out that women who were poorer were least likely to live in homes with complete bans on smoking. This was true for all women (African American, Asian, Asian/Pacific Islander and White). 56% of the poorest women had a complete ban on smoking in the home compared to 67% of women living above the poverty level. Additionally, poorer women who permitted smoking anywhere inside the home, had a lower likelihood of quitting than women who did not permit smoking anywhere. There are huge provider gaps in two of the poorest counties in Arkansas where all counties are considered medically underserved. Lee County has a ratio of 3,340 to 1 provider and Phillips County with a ratio of 2,900 to 1 provider.

The study sample consisted of 200 African American women who received food assistance, lacked access to broadband internet and telephones and nearly no telehealth capabilities. The control group only received educational materials while the intervention group received educational materials and motivational counseling via phone calls. The aim was to help women maintain a smoke-free home from all tobacco products with clean indoor air and to help them quit smoking.

In a previous research study, Dr. Fagan found that poorer women, regardless of race, were more likely to live in homes without clean indoor air and were less likely to have house rules against smoking indoors, leading to a lower likelihood of quitting smoking. The same was found regarding different levels of employment. Unemployed women were less likely to have partial bans on tobacco use in the home compared to women who worked part-time and

women who worked full-time were most likely to have partial bans on tobacco use within the home. Among women who had full bans on tobacco use in the home, 29% planned to quit within the next 30 days whereas 11% of women with partial bans reported an intention to quit within 30 days. The study also identified a higher level of nicotine dependence among women who smoked menthol cigarettes and women with greater levels of social deprivation.

The study began before the COVID-19 pandemic and continued with modifications made to how the study was conducted. For example, rather than in-person counseling and motivational interventions, they were conducted via telephone. The pandemic introduced another factor, the level of food insecurity. The motivational interventions were conducted via phone not only due to COVID, but also because of the lack of transportation for participants to attend counseling sessions. Prior to the pandemic the interventions were conducted in-person with counselors conducting home visits to prevent participants from feeling discouraged. With continued funding from NIMHD, the study was able to provide cell phones, tablets and jetpacks to participants so they would have stable access to broadband internet in order to communicate with their counselors. Another contextual factor accounted for was a history of oppression of African Americans in Arkansas.

Dr. Fagan shared a few important points related to policy interventions and reaching African American women in rural areas. She stated addressing low resource context must be part of any intervention. The reach of evidence-based strategy, implementation of voluntary home smoking rules has low penetration among poor African American women in rural areas. She also noted that voluntary policies that ban all tobacco product use in the home is low and product specific home bans for cigars and other tobacco products is high. In general, the most successful way to reach rural African American women with policy interventions is developing and distributing culturally relevant intervention materials.

Dr. Fagan discussed *Racsexism* in peer-review journals citing a comment from the editors that smoking among black women is not a problem and therefore they did not see value in publishing a paper on [Heterogeneity in the Smoking Behavior of African American Women](#) (Garret et al. 2011 MMWR).

Dr. Fagan proceeded to discuss factors that influence how rural communities access evidence-based interventions and practices related to COVID-19 as it relates to CEAL. The Black Health Block was created through the Arkansas Community Engagement Alliance Against COVID-19 Disparities. The Black Health Block vision is to create a COVID-19 free state, where no one is left behind to suffer from the devastating effects of the infectious disease and its unintended consequences. This study looked at the rates of infection and vaccination among rural African American populations in rural Arkansas. A coalition, supported by local organizations and businesses and comprised of 125 individuals, was established to hear testimonials, and provide up-to-date and accurate information on COVID-19 at the time that the information was gathered. One baseline survey collected data on an organization's capacity building domains, sustained implementation domains and CBO

perceived readiness regarding the effects of COVID-19. Data showed that 24% of the coalition reported that their mission had changed during COVID-19, 90% reported that they implemented protective policies for employees, and 92% reported that their policies changed considering COVID-19. Of the participating organizations, 78% said they initiated education on COVID-19 for their employees and approximately 64% did the same for their clients. When asked about business capacities and resources and the impact of the pandemic, on average businesses reported 33% of their employees were laid off/furloughed and 25% left their jobs. Of the already limited support capacities of these local organizations, only 54% having received any form of financial support to address COVID-19. When asked if they would have sufficient resources for next year, nine percent strongly agreed that they had sufficient resources, 41% said COVID-19 had strained their resources for the next year, and 60% said COVID-19 had strained their resources in general.

When discussing the level of trust in the vaccine with these organizations, it was found that workers tended to have higher degrees of trust than their clients. Researchers also conducted a door-to-door campaign gathering data on how the community as a whole felt about the vaccine. They found a large resistance to the vaccination of children, distrust in the government and many wondering why the government suddenly was pushing the vaccine on them when it had never cared about their personal health before. This door-to-door campaign led researchers to create and distribute tool kits that included N95 masks and door hangers with tips for prevention and precautionary measures to take. Dr. Fagan stated that community intelligence is a critical need during a pandemic in rural areas. Rural community resources are low for chronic and infectious disease risks. Vaccination rates are very low in some Arkansas counties, with no counties keeping up with the national vaccination rate. The context that influences how to eliminate COVID-19 disparities include the capacity community organizations and business have to support COVID-19 prevention and protection.

Dr. Fagan discussed the fact that community and policy interventions do not benefit everyone equally. Saving communities means that one must constantly consider context and reach as an evolving process. One must be malleable to changes in research to attend to the needs of communities that experience chronic and infectious disease disparities. Dr. Fagan provided recommendations for consideration:

- Provide rural and racialized communities access to evidence-based interventions.
- Test the efficacy of evidence-based interventions for diverse groups.
- Develop interventions that are designed for disparate groups.
- Create infrastructure to support interventions for disparate groups in their communities.
- Create supportive health, regulatory, and social policies to reduce harm to disparate groups.
- Act on and change the social and structural determinant that influence tobacco use and exposure.

NIMHD TRIENNIAL INCLUSION REPORT

Nathan Stinson, Jr., PhD, Director, Division of Community Health and Population Sciences, NIMHD

Dr. Stinson gave a presentation on the Triennial Inclusion Report on clinical research at the NIMHD for 2019 through 2021. Dr. Stinson explained that the intent of the NIH's inclusion policies was to ensure that the distribution of participants by age, sex, gender, ethnicity, and race, reflected the populations needed to accomplish the scientific goals. Dr. Stinson went over the history of the NIH's policy evolution regarding inclusion in studies and the reporting standards that came with that evolution; much of which was the result of the 21st Century Cures Act. Dr. Stinson went over technical term definitions, important for the understanding of the report; clinical research and Phase III clinical trials.

Dr. Stinson discussed the roles of responsibility that the different components of the NIH, applicants for grants or property agreements, with the NIH's support, bore in terms of inclusion. The NIH was responsible for ensuring compliance and training amongst its staff, investigators, applicants, peer reviewers and grantees on following the policies on rules and regulations regarding inclusion. The NIH was also responsible for monitoring participant recruitment and providing oversight for its funded projects. Applicants were required to provide inclusion plans with planned enrollment tables that included proposed distributions across sex, gender, race and ethnicity. In age defined Phase III clinical trials applicants were required to also provide descriptions of their plan for a valid analysis and evaluation of potential group differences among sex, gender, race, and ethnicity. In the past Phase III clinical studies were also required to provide annual cumulative enrollment data but a few years back the NIH had changed their procedures so that principal investigators could update their data forms in a more real-time manner. Dr. Stinson also discussed the role of Grants Management in ensuring that the terms and conditions of an award were included in the notice of award and were noted in the grant file.

Dr. Stinson went over the inclusion data that had been compiled from NIH supported projects over the past three years; the NIMHD had not supported many Phase III clinical trials, the lower number since many of the studies supported by NIMHD simply did not meet the NIH definition of a Phase III clinical trial. Turning towards the inclusion of sex and gender in NIH versus NIMHD research projects; overall in NIH clinical research females represented approximately 50-60% of participants with 5% reporting as none or other and the rest being male. The ratio of representation of sex and gender were similarly reflected in NIMHD studies, just on a smaller scale.

Regarding ethnic minorities represented in NIMHD studies there had been a decrease over the past three years, primarily due to large studies that were ongoing in 2019 but phased out between 2020 and 2021. Two notable large studies that had ended in that period included a study on chronic kidney disease and association with dialysis, and one on cardiovascular health and strokes. It was hypothesized that COVID-19 may have had an impact on the

representation of minority ethnic groups due to an increase in hesitancy towards in-person enrollment, and changes in research methodology for recruitment of participants from what was initially proposed in research applications.

For all NIH studies, Whites represented 53.4% of participants; Native Hawaiian participation was not detectable for NIH overall but within the NIMHD accounted for 1.6%; African Americans made up 17.7% of overall NIH participants while within the NIMHD African Americans accounted for 29.6%; overall Asian populations made up 12% of participants in NIH studies; Native Americans and Alaskans made up 0.7% of NIH participants, combined the two represented 3% of participants in NIMHD studies. Hispanic/Latino and unknown or unreported populations both represented 10-11% of participants in NIH studies. On ethnic minority population enrollment rates in U.S. only NIH studies versus all NIH studies, compared to NIMHD U.S. only studies, rates were very similar. Dr. Stinson elucidated that the inclusion enrollment reports were not aggregated by race or ethnicity, making it unclear whether enrollment rates were concentrated in a few specific studies or distributed across the NIH's portfolio. The topic shifted briefly to future data collection and ways in which the process and categorization could be improved to enhance understanding of the implications of said data.

On the topic of age representation, 58% of participants across the NIH were adults 18-64 years old with the remaining 42% split nearly down the middle between children and adults 65 or older. Within the NIMHD the majority of participants were 18-64 in age with 10% being children and a low percent being 65+. Dr. Stinson then proposed further investigation into the participants categorized as none or unknown in regard to race and ethnicity, suggesting that deeper investigation could offer better research results on racial and ethnic health disparities. This transitioned into discussion on the RCDC system and the terms it used to categorize studies versus the purposes of the studies. Through more investigation the RCDC might be able to yield more granular results that were relevant to the work of the NIMHD when it came to participant ratios and the fields of study that the NIMHD tended to focus on, the NIMHD just needed a better understanding of the labels by which studies were coded in the system.

APPROVAL OF CONCEPTS

Understanding and Addressing Misinformation among Populations that Experience Health Disparities; Presenter: Nancy Jones, PhD, Program Officer, Division of Community Health and Population Sciences

The object of this initiative will seek to (1) understand the underlying mechanisms, and (2) to test interventions for addressing and mitigating impacts of health-related misinformation and disinformation on health disparities and the populations that experienced health disparities. Due to the heightened impacts of health misinformation during the COVID-19 pandemic, this initiative aimed to address health misinformation in all fields of public health.

The difference between misinformation and disinformation was that disinformation was the deliberate production and/or dissemination of false information to manipulate public opinion and behavior in a deceptive way. Pointing to the elevation of social media and growing distrust towards the government during the COVID-19 pandemic, Dr. Jones discussed the modes by which misinformation spread among the American public and became a threat to public health and health equity. Lower levels of education, health literacy, as well as current and historic distrust may have made more individuals susceptible to misinformation and disinformation, with certain communities being targeted by tailored disinformation. To address these issues and underlying causes of susceptibility, several fields of investigation needed to be involved. Firstly, psychology and behavioral sciences to research cognitive and social processes that underlie beliefs, attitudes and perceptions relevant to misinformation and disinformation and how they are processed. Studying these factors could also lead to methods of counteracting misinformation and disinformation.

Dr. Jones relayed that a common misconception on the transmission of misinformation and disinformation was that individuals continued to share and spread misinformation due to a lack of access to verified sources and outlets, while in practice it was more common that the individuals sharing the false information were simply following an intuitive rather than deliberative thought process. Individuals were more likely to share misinformation if they perceived it as having come from a trustworthy and valid source, a perspective that agreed with their world view or their thought process was driven by emotions such as fear, or anger and the source validated their emotions.

Another important field of study that Dr. Jones discussed was on the dissemination of misinformation was health communication sciences, which could aim to improve health literacy at organizational and community levels. Research in this field needed to focus more on how reputation and trustworthiness affected the impacts that public health organizations could have in communities dealing with misinformation, while looking into methods to partner with local community representatives to have facilitators that come from the communities they wished to reach. This route of communication was found to be extremely important in communities that experienced health disparities.

Dr. Jones discussed the need for studies on understanding how different social constructs, such as families, social networks, communities, and others, shape the understanding and use of public health information, emphasizing that without a greater amount of community level-based research there could be no improvements to the rates of health misinformation and disinformation among population groups dealing with health disparities. This dealt not only with the matter of COVID-19 but in mental health, HIV AIDS, STIs, excess morbidity and fatality rates and many other public health issues that were affected by the spread of misinformation and disinformation.

Dr. Zorrilla made a motion to move the concept forward, which was seconded by Dr. Mustanski. The Council proceeded to a vote which approved the concept unanimously.

PUBLIC COMMENTS

There were no public comments.

CLOSING REMARKS AND ADJOURNMENT

Dr. Pérez-Stable closed the meeting by thanking all of those who contributed to the presentations and the individuals in attendance who participated in the discussions. After stating that the next meeting be held in September and in-person, Dr. Pérez-Stable adjourned the meeting.

END NOTE:

REVIEW OF GRANT APPLICATIONS – CLOSED SESSION

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

Denise Russo, PhD led the second level review of grant applications submitted to NIMHD programs. Council Members and Staff were instructed on conflict of interest and confidentiality regulations. Members and Staff absented themselves from the meeting room and discussion for which there was a potential conflict of interest, real or apparent.

The Council considered 287 competing applications requesting an estimated \$7,317,762 in total costs for year 1 for non-fellowship grants. Funding recommendations for all applications submitted in response to funding opportunity announcements were reviewed. Applications submitted in response to program announcements and special program review announcements were considered by the Council through En Bloc voting.

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

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