Department of Health and Human Services
National Institutes of Health
National Center on Minority Health and Health Disparities

National Advisory Council on Minority Health and Health Disparities
Wednesday, February 23, 2005
Meeting Minutes

The National Advisory Council on Minority Health and Health Disparities met on February 23, 2005 at the Doubletree Hotel & Executive Meeting Center in Rockville, Maryland. Lisa Evans, J.D., Executive Secretary, National Center on Minority Health and Health Disparities (NCMHD) called the meeting to order at 8:35 a.m. John Ruffin, Ph.D., Chairman of the National Advisory Council on Minority Health and Health Disparities and NCMHD Director presided over the meeting. Caroline Kane, Ph.D., Adjunct Professor, University of California, Berkeley, served as chair designee and facilitated the proceedings. In accordance with the Federal Advisory Committee Act (FACA), the meeting was open to the public from 8:35 a.m. to 12:45 p.m. and reconvened in open session from 1:30 p.m. to 4:15 p.m.

Council members present:

John Ruffin, Ph.D., Chair
Roger Bulger, M.D., F.A.C.P.
Thomas E. Gaiter, M.D.
Ruth Johnson, J.D.
Caroline M. Kane, Ph.D.
Melvina McCabe, M.D. (via teleconference)
Grace L. Shu, D.O.M., Ph.D.
Louis W. Sullivan, M.D.
M. Roy Wilson, M.D.
Regina M. Benjamin, M.D., M.B.A.
Carl Franzblau, Ph.D.
Pamela V. Hammond, Ph.D., F.A.A.N.
Warren A. Jones, M.D.
Elisa T. Lee, Ph.D.
Eric Munoz, M.D.
Pitambar Somani, M.D., Ph.D.
Augustus A. White, III, M.D., Ph.D.

Ex-officio members present:

David B. Abrams, Ph.D.
Michael J. Fine, M.D., M.Sc.
Kevin R. Porter, M.D.

Executive Secretary:

Lisa Evans, J.D.

OPENING REMARKS

Dr. Ruffin welcomed the group to the eighth meeting of the National Advisory Council on Minority Health and Health Disparities. He noted that NCMHD was entering its 4th year of operations and that preliminary discussion about the Center's reauthorization had already begun. He explained that NCMHD staff members were preparing for upcoming appropriation hearings and updating Congress on the Center's accomplishments.

Dr. Sullivan provided an update on the implementation of the report, *Missing Persons: Minorities in the Health Professions*. Issued in September 2004, the Sullivan Commission report addressed the health status of minority populations and highlighted the under-representation of minorities in the health professions. The report contained 37 wide-ranging recommendations, such as strengthening the science curriculum in high school, broadening the K-12 pipeline, and creating a bridge between community colleges and baccalaureate institutions to encourage more minorities to enter the health professions. In addition, Dr. Sullivan spoke of the need to change the funding strategy to support minority students entering the health professions. The shift from providing scholarships to loans has had a very negative impact on low-income students who often finish their medical training with insurmountable debts.

Dr. Sullivan noted that the Sullivan Commission's findings have had a ripple effect. For example, the American Medical Association (AMA), National Medical Association, and National Hispanic Medical Association have come together to develop a Health Disparities Institute to be housed at the AMA. The Institute will develop policies and programs that further advance the Commission's recommendations and promote diversity within the health professions. Dr. Regina Benjamin added that, in June 2005, the AMA Council on Ethical and Judicial Affairs would issue a report on the ethical implications of health disparities. The report will be used to guide AMA policy-making and will focus increased attention on the issue.

The Sullivan Commission recently joined forces with the Institute of Medicine (IOM) Committee, which released the report *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* in February 2004. The two groups began operating out of the Joint Center for Political and Economic Studies in Washington, DC, as of January 1, 2005. The Joint Center Health Policy Institute will work on implementing the many recommendations generated by both the Sullivan Commission and the IOM. Dr. Sullivan stated that The Institute would continue for at least the next three years, if not longer, with funding from the Kellogg Foundation and a broad base of funders.

Finally, Dr. Sullivan reported on his work developing an alliance between the Medical Centers of Virginia Commonwealth University and Nebraska Health Sciences. The initiative is aimed at: 1) increasing the number of students from Historically Black colleges in Virginia that end up in academic health centers; and 2) creating more opportunities for research and faculty interaction.

Dr. Ruffin introduced the new members of the Advisory Council: Pamela Hammond, Ph.D., F.A.A.N., Dean, Hampton University School of Nursing; Warren Jones, M.D., Executive Director, Mississippi Division of Medicaid; Thomas E. Gaiter, M.D., Medical Director, Howard University Hospital, Associate Dean for Clinical Affairs; and Pitambar Somani, M.D., Ph.D. He also welcomed David B. Abrams, Ph.D., the new Director of the NIH Office of Behavioral and Social Sciences Research.

REVIEW OF CONFIDENTIALITY & CONFLICT OF INTEREST

As Chair designee, Dr. Kane reviewed several Advisory Council policies and procedures. She reminded the Council that its meetings are open to the public and that closed sessions were reserved for the review of grant applications. She reminded members that the Advisory Council's standards of conduct were in desk folder. She reviewed the confidentiality and conflict of interest policies citing a few examples of potential and urged members to reconcile any potential conflicts in advance and to consult the official standards of conduct for more details.

CONSIDERATION OF THE ADVISORY COUNCIL'S SEPTEMBER 2004 MINUTES

The Advisory Council reviewed the September 15, 2004, meeting minutes and voted to approve the minutes with one correction: to reflect that Roger Bulger, M.D., F.A.C.P. was present for the September meeting.

FUTURE MEETING DATES & OTHER ADMINISTRATIVE MATTERS

Dr. Kane announced the Council's 2005 and 2006 meeting dates: June 14-15, 2005; September 13-14, 2005; February 21-22, 2006; June 13-14, 2006; and September 12-13, 2006.

At the previous meeting, Council members were given a copy of the 2004 NCMHD Advisory Council operating procedures to review and provide feedback. After not receiving any request for changes to the document, Dr. Kane called for a motion to approve the Council's operating procedures for 2005. The motion was made, seconded, and approved unanimously.

DIRECTOR'S REPORT

Dr. Ruffin was joined by NCMHD senior staff to report on the Center's programs, management, and budget activities. He gave a brief history of the NCMHD's six core programs – the Centers of Excellence Program (Project EXPORT), the Loan Repayment Program, Endowment Program, Minority Health and Health Disparities International Research Training Program (MHIRT), the Community Based Participatory Research Program (CBPR) and the Research Infrastructure in Minority Institutions Program (RIMI).

In FY 2005, the NCMHD only released a P20 Request for Application (RFA) for the Project EXPORT program, enabling current R24 institutions to apply for new funding and continue the

growth of their programs. The RFA for the Community-Based Participatory Research Program was released in early February 2005 following earlier approval by the Advisory Council of the program's concept. NCMHD issued its first RFA for the MHIRT program in October 2004 and received 45 applications. After first-level reviews are completed, the Advisory Council will conduct a second-level review at its June 2005 meeting.

Jerome Wilson, M.A., Ph.D., Associate Director for Scientific Program Operations, elaborated upon the NCMHD statutorily mandated-programs.

Centers of Excellence (Project EXPORT)
Project EXPORT Centers are located in 29 states, as well as Puerto Rico and the U.S. Virgin Islands. Dr. Wilson described the three funding mechanisms used for the Centers of Excellence Program in more detail.

- Twenty-seven institutions are funded through the R24 planning grant; some are teaching institutions, while others are more research-oriented.

- P20 funds twenty-one Project EXPORT Exploratory Centers.

- P60 is for Project EXPORT Comprehensive Centers. These P60 institutions are expected to produce high quality research, which will help reduce health disparities.

Endowment Program
Dr. Wilson shared a list of the 14 institutions funded by NCMHD's Endowment Program. The Endowment Program helps institutions build their infrastructure and enhance research and teaching opportunities; all of these efforts are aimed at reducing health disparities.

Loan Repayment
The NCMHD Loan Repayment Program is essential for building human capital and research capacity. In FY 2004, NCMHD received 422 applications (reflecting 36 new extramural clinical research applications, 264 health disparities scholars, and renewals from 32 clinical researchers and 90 for health disparities scholars). NCMHD made 243 new awards: 19 awards for extramural clinical research; 133 awards to health disparities scholars; and renewals for 24 clinical researchers and 67 health disparities scholars.

Dr. Wilson provided the racial and ethnic distribution of the loan repayment awardees: 90 individuals are African American; 23 are Asian; 89 are Caucasian; 30 are Hispanic; seven are Native Americans; one is Native Hawaiian; and 13 are from unknown ethnic/racial backgrounds. He also highlighted the scholars' research focus, including colorectal cancer among Korean Americans, barriers to cervical cancer screening for Hispanic women in Boston, and other initiatives involving cardiovascular disease, diabetes, infectious disease, mental health, obesity, substance abuse, and access to health care.

An Advisory Council member asked which NCMHD-supported institutions were engaged in obesity-related research and asked to be provided with a full list of NCMHD grantees and their particular research focus. NCMHD staff indicated that such a list could be provided. Dr. Ruffin added that NCMHD invites grantee institutions to present at each Advisory Council meeting to help Council members understand the scope of research being supported. He encouraged Advisory Council members to review the written profiles of the Project EXPORT grantees and suggest institutions they would like to have invited to future Council meetings.

Another Council Member inquired whether NCMHD encourages institutions receiving multiple NIH awards to collaborate and communicate with other awardees in order to minimize "stove-piped research" and maximize the impact of NIH dollars. Dr. Wilson responded that NCMHD is working on several activities to bring loan repayment recipients and Project EXPORT Centers together to discuss mutual research interests and better coordinate their efforts. Dr. Ruffin added that NCMHD is striving to institute a culture change within NIH that encourages partnerships among the NIH Institutes and Centers (ICs) on multidisciplinary issues.

Community-Based Participatory Research Program
Francisco S. Sy, MD, DrPH, Chief, Community-based Research and Outreach Program, described the steps to launch the community research program. Dr. Sy defined community-based participatory research as scientific inquiry conducted in communities and in partnership with researchers. This research model calls for community partners to be full participants in each phase of the study (from study conception to dissemination).

Dr. Sy then outlined the concept for a new community-based participatory research initiative. The initiative will begin with 3-year planning grants, followed by competitive 5-year grants focused on intervention, and then competitive 3-year dissemination grants. The initial focus of these planning grants is partnership development, community needs assessment, identification of disease condition, and planning for intervention methodology. During the second and third years of the grant, recipients will need to pilot their interventions using community-based participatory research principles.

Dr. Sy added that NCMHD is currently reviewing all outreach activities conducted by current Project EXPORT grantees. After this review, NCMHD will develop a comprehensive outreach plan and provide funding opportunities for community-based participatory research partnerships to conduct outreach and dissemination research.

In response to questions from Advisory Council members, Dr. Sy clarified that grantees will be required to develop community boards to ensure true community participation. In addition, ranges of community organizations (including state or local government entities) are eligible to partner with academic researchers to apply for these grants. Advisory Council members urged that NCMHD consider (1) scheduling site visits to ensure that full community participation occurs and (2) extending program time frames, if needed, because building trust among community partners takes time, often more time than anticipated.

Management

Dr. Ruffin provided an update on personnel moves within NCMHD. He announced that the NCMHD recently recruited Ana Velez to be the NCMHD Budget Officer. Ms. Velez comes from the National Institute of Diabetes & Digestive & Kidney Diseases. In addition, interviews are being conducted for four other positions, including program director for the Endowment Program, two health scientist administrators to administer the RIMI, MHIRT and internship programs, and a budget analyst.

Dr. Kanda then introduced Tanya Hilton, the lead for the Booz Allen Hamilton consulting team that has been working with NCMHD on conducting an organizational assessment.

Booz Allen Hamilton is working with NCMHD on five objectives: (1) assess changes to strategic direction and goals; (2) determine mission/functions to be supported; (3) determine workforce realignment; (4) determine new organizational structure; and (5) identify next steps for implementation. To accomplish these objectives, the consultant team is conducting project planning and document review (phase one); working on the strategic business definition and holding discussions with stakeholders (phase two); and assessing the current alignment of structure/workforce/workload and conducting gap and solution analysis (phase three). The final phase will involve developing recommendations to address identified gaps; create a road map for a restructured organization, functions, roles and responsibilities; and determine next steps for implementation (e.g., revision of procedures, responsibilities, and functional statements).

Following the Booz Allen update, Dr. Kane discussed the January 2005 meeting with NIH Director Dr. Zerhouni about NCMHD's activities and the available resources. Dr. Zerhouni reiterated his strong commitment to health disparities and suggested that Advisory Council members meet with individual ICs to expand joint research activities and increase collaboration.

Advisory Council members discussed the different ways to frame the need for more resources to fund health disparities research. One strategy discussed was to highlight the economic implications of health disparities; people who are healthy are also able to work, pay taxes, and raise their families. NCMHD should help spread the message that investing in efforts to eliminate health disparities also means investing in a better economic future for our nation.

Reporting Requirements

Dr. Ruffin discussed the status of the *NIH Guidance on Minority Health and Health Disparities Research Definitions and Applications Methodology*, the report captures the amount of NIH resources dedicated to health disparities. In order to generate this report, NIH developed a definition of minority health and health disparities and a consistent methodology to calculate how resources were spent on health disparity research. The draft NIH Budget and Methodology report is based upon the new reporting guidelines issued by the NIH methodology committee. Currently, the report is under clearance with the NIH Office of the Director and HHS Office of the Secretary before its eventual transmittal to Congress.

Another key report is the *NIH Annual Report on Health Disparities Research,* which describes the annual progress among the ICs in reducing and eliminating health disparities. Currently, the FY2002 - 2003 reports are being compiled using the new reporting guidelines. Advisory Council members will receive these draft reports for review and comment before their submission to NIH for review and clearance.

NCMHD staff also is coordinating the compilation of *NIH Health Disparities Strategic Plan, FY 2004- FY 2008.* The report outlines the collective vision for health disparities research among all 27 ICs. Ultimately, the Secretary of HHS will sign off on the report. Dr. Ruffin expressed thanks to Dr. M. Roy Wilson, chair of the Advisory Committee Strategic Plan Subcommittee, and NCMHD staff for their careful review of this important document.

Dr. Ruffin concluded by providing an update on the Institute of Medicine's (IOM) assessment of the NIH Health Disparities Strategic Plan. IOM has established a study committee and, in December 2004, Drs. Elias Zerhouni, John Ruffin, Wilson, Kane, and Sullivan appeared before committee members to brief them.

Budget

NCMHD Executive Officer Thomas Williams, M.B.A., discussed the Center's history and budget. Mr. Williams relayed that the overall FY 2004 budget for NCMHD was $191.5 million, an increase of $5.8 million from the previous year. The following breakdown reflects each program's budget and its relative percentage of the overall FY 2004 budget:

Endowment	$44.4 million (23.2 percent of the budget)
Project EXPORT	$55.5 million (29 percent)
Collaborative projects with other ICs	$44.9 million (23.4 percent)
MHIRT	$3.9 million (2.1 percent)
LRP	$10.4 million (5.4 percent)
RIMI	$13.8 million (7.2 percent)
Center Operations	$7.7 million (4 percent)
SBIR/STTR	$5.3 million (2.8 percent)
NIH Taps (an assessment that all ICs must contribute)	$5.6 million (2.9 percent)

Dr. Ruffin clarified that the collaborative projects represented the continued tradition of working collaboratively with other ICs. For example, NCMHD, along with eight other ICs, is funding the Mississippi Delta project, an initiative aimed at medically underserved populations in that region. He shared that Dr. Zerhouni would like other ICs to assume more financial responsibility for their health disparities portfolio. While NCMHD is committed to co-funding health disparities activities throughout NIH (like the Jackson Heart Study with National Heart, Lung, and Blood Institute), the NCMHD also needs to expand its own portfolio.

Dr. Ruffin underscored that only 4 cents of every dollar was spent on NCMHD operations. Thus, NCMHD spends 96 cents of every dollar in its budget on research and other NIH requests for assistance.

Mr. Williams resumed his analysis of the NCMHD budget. After experiencing increases of 18-20 percent for the FY2002 and FY2003 budgets, recent budgets have had more modest increases. In FY2005, the budget increased 2.4 percent to $196.2 million and the proposed FY2006 budget increased .6 percent to $197.4 (consistent with the overall NIH percentage increase). He outlined how NCMHD programs will fare under these budget levels:

Endowment	2005	$47.5 million	14 awards est.
	2006	$47.6 million	14 awards est.
Centers of Excellence	2005	$64.1 million	71 awards est.
	2006	$66.6 million	71 awards est.
Loan Repayment	2005	$8.9 million	242 awards est.
	2006	$9.0 million	242 awards est.
RIMI	2005	$16.5 million	19 awards est.
	2006	$16.5 million	19 awards est.
MHIRT	2005	$5.2 million	
	2006	$5.2 million	
Community-Based Participatory Research	2005	$3.5 million	
	2006	$3.75 million	
Staffing	2005	30 FTEs	
	2006	30 FTEs	

Mr. Williams also noted the reasons for variations in funding levels from previous years. For example, the decrease in funding for the Loan Repayment program (from $10.4 million in 2004 to $8.9 million in 2005) was due to the NCMHD allocating additional funds in 2004 after receiving a surge of outstanding loan repayment applications. Thus, the 2005 funding level of $8.9 million was actually a return to the planned trajectory for the Loan Repayment program.

Finally, Mr. Williams discussed the history of staffing levels. At its inception in 2001, NCMHD had 9 FTEs. In 2002 and 2003, NCMHD had 26 authorized FTEs and used 19 and 24 staffing slots respectively. In 2004, the FTE level was increased to 30 FTEs in the middle of the year, a level which has remained constant since that time.

Discussion of Director's Report

After the Director's Report, Advisory Council members focused on the budget figures and the implications for health disparities research, particularly the challenges presented by an increasingly diverse society. Several members called for making a strong, yet appropriate, statement about the tremendous need for more financial resources and staffing.

Discussion also centered on NCMHD's low overhead, which could end up shortchanging the NCMHD's efforts. While the rate of 4 percent is comparable to what other ICs spent on administrative costs (typically 3-5 percent), NCMHD is still a new entity that continues to launch programs and incur startup expenses. Thus, it may not be meaningful to compare NCMHD's overhead rates to other ICs. Ultimately, spending too little on operating expenses can be problematic.

Another Advisory Council member expressed interest in a breakout of funding directed to activities to enhance the K-12 pipeline. Dr. Ruffin responded that NCMHD has partnered with other ICs, including the National Center for Research Resources, to provide funding support for K-12 education activities.

In response to the discussion, Dr. Kane proposed an action item for the Advisory Council. She suggested the Council compose a follow-up letter to Dr. Zerhouni. Members requested that the letter to thank Dr. Zerhouni for the January 2005 meeting; suggest creative ideas for allocating additional resources to NCMHD; and indicate that the Council looks forward to his response to the January 2005 meeting. Dr. Kane observed that the Council had reached consensus that an interim letter should be sent to Dr. Zerhouni reiterating concern about NCMHD's budget and staffing challenges.

SUBCOMMITTEE REPORTS

Loan Repayment Subcommittee

Dr. Lee gave the report for the Loan Repayment Subcommittee. Ms. Kenya McRae, NCMHD LRP Program Officer, advised the Subcommittee that NCMHD had received 365 new loan repayment applications, which was 65 more applications than the previous funding cycle, or a 25 percent increase. She also noted the retention rate for the 2003 funding cycle: 155 scholars were eligible for renewals and 126 (or 80 percent) submitted renewal applications. She reported that scholars from 41 states plus Washington, DC, Puerto Rico, and the U.S. Virgin Islands had submitted applications. The three states with the most applicants were California (71), New York (51), and Massachusetts (38). Their proposed research activities covered a large spectrum, including cancer, cardiovascular disease, diabetes, health care access, HIV, mental health, and rural health. The Subcommittee discussed how to market the loan repayment program further to reach the nine states with no applicants.

Dr. Ruffin commented that there may be NCMHD scholars from those nine states; who are now residing in other states where their institution is located. NCMHD does not capture that data, but there may be, in fact, some participation from those "missing" nine states.

Research Endowment Subcommittee
As Subcommittee Chair, Dr. Kane provided the report for the Research Endowment Subcommittee. Dr. Kane summarized some of the endowment program requirements, including (1) The award calculation must be based on existing institutional assets and the degree to which the institution serves health disparity students; (2) institutions must submit both budget and investment strategies; (3) institutions can only spend income from the endowment, not the body; and (4) recipients must submit annual progress reports on the endowment's performance.

The 14 institutions receiving endowment funding in 2004 came from 12 states, as well as Washington, D.C. and Puerto Rico. The 2005 RFA was modified to make it more consistent with the NCMHD mission to eliminate health disparities by providing explicit instructions on how institutions calculate their endowment; requiring disaggregated student and faculty profile data; and allowing peer reviewers to evaluate how the institution will advance the health disparities research agenda with endowment income. The 2005 RFA was released on February 4, 2005, with applications due in April 2005. The Advisory Council will conduct a second-level review of these applications at its September meeting.

Project EXPORT Subcommittee
Subcommittee Chair Dr. Augustus White referred Advisory Council members to the written Project EXPORT Subcommittee report in their materials. He also mentioned the Project EXPORT Principal Investigators meeting held September 21 – 22, 2004, a well-attended and well-received meeting. He thanked Dr. Kane, Dr. Bulger, and Dr. Virginia Cain for their help with facilitating some of the sessions at that meeting.

Strategic Plan Subcommittee
Dr. M. Roy Wilson discussed the process for reviewing the *NIH Health Disparities Strategic Plan 2004-2008*. NCMHD requested public comment on the strategic plan in 2004 and provided those comments to NIH ICs and Offices for their consideration. The NIH ICs and NIH Office of the Director have completed their revised draft and all Advisory Council members are in receipt of those drafts. The Strategic Plan Subcommittee is awaiting additional comments from other Council members. One Council member noted that the strategic plans had improved dramatically since the previous report.

CULTURALLY COMPETENT CARE EDUCATION VIDEO

Dr. White arranged for the Advisory Council to screen a training video produced by the Culturally Competent Care Education Committee at Harvard University. He prefaced the viewing by noting that well-meaning colleagues often do not know what culturally competent care means. The video was designed to increase awareness about culturally competent medical care and

stimulate discussion about culturally competent care, including its relationship to, and potential impact on, health disparities.

Following the video, Advisory Council members discussed the distinction between being culturally competent versus culturally proficient. Cultural competence presents a danger that people will cease efforts once they consider themselves competent. The ultimate goal should be to move beyond competency and integrate culture into core values and daily activities. Others noted the tension between learning about different cultures and yet not stereotyping people from that culture. Professional education relies on role modeling and corrective feedback to advance culturally aware attitudes, knowledge and skills.

Dr. White relayed that Harvard University is still determining how this teaching tool will be used and that those interested in copies should contact him. Council members urged that the video be made available to organizations like the American Medical Associations, medical colleges, and health professional schools to stimulate dialogue.

NCRR HEALTH DISPARITIES UPDATE

Judith Vaitukaitis, M.D., Director of the NIH National Center for Research Resources (NCRR) presented an overview of NCRR's activities and underscored how NCRR's agenda complements the NCMHD mission.

The NCRR is congressionally mandated to "strengthen and enhance the research environments of entities engaged in health-related research by developing and supporting essential resources." The goal is to help develop the nation's research infrastructure, namely improve research facilities, competitively trained investigators and career development, and better access to research technology and tools. Comparing the research infrastructure to a three-legged stool, Dr. Vaitukaitis commented that if one of these "legs" is imbalanced, the other two legs cannot function normally.

To develop its strategic plan, the NCRR obtained input from more than 6,000 investigators. The plan, *Challenges and Critical Choices*, includes specific strategies for addressing health disparities. The NCRR also further defined and highlighted its support for health disparities research in the NIH Health Disparities Strategic Plan FY 2004-2008. Dr. Vaitukaitis reviewed some of the challenging questions facing researchers: Are health disparities molecular-based; acquired; result of diet; mediated genetically; the result of poor health care; and/or the result of lack of trust in physicians or access to health care? The NCRR provides support to studies that try to discern why health disparities exist and test approaches to eliminate them.

The NCRR also operates several programs to improve the nation's research facilities and supports various activities aimed at building the nation's research capacity. The NCRR provides construction and renovation grants to assist institutions with upgrading or building their research laboratories.

In addition, the NCRR provides shared instrumentation grants that allow at least three NIH-supported investigators to purchase and use off-the-shelf instruments. One grant program pays for instruments ranging from $100,000 - $500,000 for instruments, while the high-end instrumentation program can fund instruments from $750,000 – $2 million. After releasing its high-end instrumentation RFA, the NCRR received 97 applications and made 17 awards, signaling the strong need for such support.

The NCRR also administers Institutional Development Awards (IDeA) to help underserved states (those that traditionally have not received significant levels of competitive grant funding from NIH) build their infrastructure and help their scientists better compete for funding. The 23 IDeA states and Puerto Rico represent a number of special populations: American Indians, Aleuts, Native Alaskans, African Americans, Hispanics, and Native Hawaiian/Pacific Islanders.

To foster investigator development, the NCRR supports Centers of Biomedical Research Excellence (COBRE), multidisciplinary research teams with a specific research theme that provide opportunities for junior investigators to compete for NIH research support. Another program is IDeA Networks of Biomedical Research Excellence (INBRE), designed to build collaborative partnerships between and among institutions in IDeA-eligible states. Networks include a doctoral degree granting institution or research institution and several baccalaureate institutions (in some cases, minority-serving institutions and community colleges). Dr. Vaitukaitis shared several examples of such networks, such as the Alaska COBRE (focus on health disparities in Alaskan natives), Montana INBRE (network includes tribal colleges), North Dakota INBRE (science program core at tribal colleges), and South Carolina BRIN (network includes minority-serving colleges).

The NCRR is also creating an e-research network for research centers in minority institutions (RCMI) by linking RCMIs and others via stable high-performance networks (Internet2 (Abilene) and National LambdaRail).

The NCRR also supports research training and career development at RCMIs. For example, the NCRR supports the Bioethics Research Center at Tuskegee University (which focuses on awareness of historical and contemporary medical treatment of African Americans) and the Center for Drug Research and Development at Howard University (which has a state-of-the-art research laboratory for interdisciplinary research on pharmacogenomics and pharmacogenetics). Finally, Dr. Vaitukaitis spoke of NCRR support for stronger alliances among General Clinical Research Centers (GCRCs) and Research Center in Minority Institutions – Clinical Research Centers (RCRCs) to promote collaboration among investigators and meaningful inclusion of ethnic minorities in clinical trials.

After the presentation, one Advisory Council member noted that the criteria for IDeA designation can result in unintended inequities. For example, while a state's institutions may appear successful in competing for NIH funds (and therefore, not eligible for IDeA), some institutions in

that state may have inadequate research infrastructure (e.g., institutions in rural areas or with greater minority populations), yet not be eligible for IDeA designation.

Several Advisory Council members acknowledged the NCRR's creativity and strong commitment to minority institutions. Drs. Ruffin and Kane added their thanks to Dr. Vaitukaitis for the NCRR's ongoing partnership with the NCMHD.

NCMHD EXTRAMURAL PROGRAMS HIGHLIGHTS

RIMI Program
John C. Perez, Ph.D.
Texas A&M University, Kingsville

In 1972, Texas A&M University – Kingsville (TAMUK) had virtually no research infrastructure: no equipment, no labs, no release time, and no student support. In 1973, TAMUK obtained NIH Minority Biomedical Research funding, which marked the real beginning of their research efforts. The funding allowed the university to provide release time, purchase equipment, renovate its labs, and hire students.

Dr. Perez relayed how TAMUK researchers were the first to report the existence of natural resistance to snake venom. They discovered that a gray wood rat was 140 times more resistant to the venom of a Western diamondback rattlesnake than white mice. They then found that 16 additional animals exhibited a natural resistance to venom, including hedgehogs, other snakes, and opossums. Studying the venom molecules of snakes and their impact on the body allows scientists to better understand biomedical functioning.

For many years, TAMUK focused on a single venom project. In 1996, an NIH RIMI grant was awarded. The funding provided release time for faculty; financed equipment, supplies, and lab renovation; paid for travel to professional meetings; and facilitated the hiring of eight additional faculty members in animal science, chemistry, sociology/psychology and pharmacy. RIMI funding also required researchers to interact with other faculty, which led to collaborative work and publication efforts at the university. Citing TAMUK's commitment to this research, Dr. Perez observed that the university president serves as one of the principal investigators.

Building upon the foundation made possible by the RIMI grant, TAMUK established the Natural Toxins Research Center (NTRC) in 2000. The university established a mass spectrometry center and hired lab and computer technical personnel. The Irma Rangel School of Pharmacy will be launched shortly, with the first class of students expected in fall 2006.

In April 2003, NTRC was awarded the NIH Viper Resource Center grant, which funds research and training to study the medically important toxins found in venomous animals. NTRC researchers screen venoms for molecules that may be potentially used to treat cancers, strokes and heart attacks. Researchers also are discussing testing the efficacy of anti-venoms with

pharmaceutical companies.

Housing over 400 snakes, the NTRC serpentarium has been renovated to mimic the natural conditions of a snake's environment. The serpentarium has the capacity to house up to 660 snakes. Snakes are all pit tagged with an identification number and information on each of their venom can be found in an internet database. Dr. Perez touted NTRC's Web site, www.ntrc.tamuk.edu, which receives 5,000 hits per day.

After the presentation, NCMHD staff Dr. DeLoris Hunter commented that TAMUK's experience and the NTRC are excellent examples of how RIMI funding can help grow research infrastructure and promote faculty development.

Loan Repayment Program

Mary Gomez Chambers, ND, CNS
University of Colorado Health Sciences Center School of Medicine

Dr. Gomez Chambers serves as the project director of a study to evaluate a patient-centered diabetes registry funded by Agency for Healthcare Research and Quality (AHRQ) and to evaluate a quality of patient care initiative funded by the Colorado Trust. The goal is to develop and test the feasibility of an automated, patient-centered diabetes registry that is geared to improve guideline-concordant diabetes care and self management. The study also will examine whether using information technology and the university's infrastructure lowers the data entry burden on medical practices and promotes improved quality.

The study recruited six diverse medical practices in Colorado, including university clinics and several clinics associated with the Salud Family Health System. Salud Clinics treat 900 patients with diabetes, the majority are Hispanics, of whom 37 percent use Medicaid and 63 percent are uninsured.

In an effort to encourage patient and clinician participation in the study and develop a registry that is responsive to their needs, researchers are customizing the registry; giving sites access to collected data; helping sites sustain the project by pursuing infrastructure grants; and conducting usability testing on all patient activation materials.

Data are collected on a quarterly basis and patients self report information via a telephone system. The study also imports data from existing clinical data sets (ICD9, lab, billing and appointment data). While researchers strive to keep data collection simple for clinics, they also have "big plans" to rollout the registry to 34 primary care site in Colorado after the feasibility study is completed.

Expressing great appreciation for the Loan Repayment Program, Dr. Gomez Chambers credited the NCMHD for opening important doors for her.

Project EXPORT Centers of Excellence Program (R24)
Dr. M. Kim Oh, University of Alabama at Birmingham (UAB)
Dr. Karyn Scissum-Gunn, Alabama State University in Montgomery (ASU)

Principal investigators Drs. Oh and Scissum-Gunn discussed the R24-supported Project Reproductive Health Disparities Awareness and Prevention (Project REAP) housed at Alabama State University in Montgomery.

Dr. Gunn explained that the team targeted adolescent reproductive health, given the traditionally higher rates of sexually transmitted diseases in southern states and the alarming rates among youth and young adults, particularly those who are poor and/or minorities. Project REAP serves the "black belt" region, a horizontal swath of land across the middle of Alabama that has a large African American population. The project's overall goal is to reduce and eliminate reproductive health disparities among adolescents.

With the current R24 planning grant, the investigators are using STD/HIV rates, unplanned pregnancy rates, and sexual risk-taking behavior as indices. The ASU-UAB EXPORT Project REAP has produced several interim outputs to date, including:

- *Community-based participatory research.* To help foster this community commitment, Project REAP has hosted various activities designed for youth in the community, including after-school programs, health fairs, and a youth forum which sponsored a trip to a civil rights museum.

- *ASU student participation.* Students have participated in several cycles of a survey and in the Public Health Region Four Chlamydia Campaign. Students also have been involved in biomedical research to help stimulate their interest in future health science careers.

- *Governor Riley's Black Belt Action Commission.* Dr. Oh serves on the Commission's health committee and has advised the group of Project REAP's activities. (www.blackbeltaction.org)

- *Training/mentoring.* The Project REAP team has given abstract presentations and workshops to help educate health professionals about adolescent reproductive health.

- *Education.* Dr. Gunn discussed the training and mentoring that has occurred between the ASU and UAB. The R24 grant has helped establish dialogue between the two institutions and led to the establishment of a public health degree program.

- *Chlamydia vaccine feasibility research.* The goals of this pilot project are to assess the feasibility of mucosal vaccine development against *Chlamydia trachomatis* and to test the immunogencity of the vaccine in mice. Preliminary findings indicate that rMOMP protein administered intranasally provided the highest antibody titer and afforded maximum

protection when challenged with live *Chlamydia trachomatis.*

The principal investigators hope to grow Project REAP's core activities and eventually compete for future P20 and P60 funding.

Project EXPORT Centers of Excellence (P60)
Stephen Thomas, PhD, FAAHB
Center for Minority Health, Graduate School of Public Health, University of Pittsburgh

Dr. Thomas highlighted the accomplishments of the Center for Minority Health at the University of Pittsburgh and extended his appreciation to the NCMHD for its financial support.

Established in 1994, the Center for Minority Health has a mission closely tied to the agenda to eliminate racial and ethnic health disparities as described in *Healthy People 2010.* The specific aim is to build community capacity to eliminate racial and ethnic health disparities. Dr. Thomas maintained that successful elimination of health disparities requires establishing trusting community partnerships designed to increase the participation of minority populations in biomedical and public health research.

To foster true community participation, the Center for Minority Health established the Community Research Advisory Board (CRAB). The 40-member board meets monthly over lunch and serves as a bridge that links researchers to the African American community. The CRAB also provides a forum for disseminating research findings; an opportunity to model cultural competence; and a framework to educate the community about research. Investigators interested in working with the community cannot obtain a letter of support unless they come before the CRAB. The Center also runs several Health Disparity Working Groups that focus on cancer, cardiovascular disease, diabetes, HIV/AIDS, immunization, infant mortality, and mental disorders (depression and bipolar disorder).

The Center for Minority Health is responsible for coordinating all minority health and health disparity research across the University of Pittsburgh's health sciences schools, including the Schools of Public Health, Medicine, Pharmacy, Dentistry, Nursing, and Rehabilitation and Health Services. As a result, the various schools coordinate their efforts and work together. Dr. Thomas commented that university-wide commitment to elimination of health disparities is paramount. He noted that the University of Pittsburgh President has been a champion of the Center for Minority Health, and his leadership has helped facilitate the Center's work with the community.

The Center also has formed partnerships with historically Black colleges and universities and minority serving institutions, including Jackson State University, University of South Alabama, University of Virgin Islands, and University of Michigan at Flint. In its mentoring role as a P60 institution, the Center lends assistance to these partners as they prepare their funding applications.

Finally, Dr. Thomas spotlighted some of the Center's numerous activities to engage the community, including:

- Health Black Family project, where workers take family health histories to create health trees and connect African Americans to their family's health information;

- African American Family Reunion, during which a genetics counselor completes histories for families, about 80 percent of whom agreed to be in the Center's research database;

- Greater Pittsburgh Measles Immunization Task Force, a result of the University teaming up with the public school system to provide immunizations to thousands of students who risked suspension due to their lack of immunization;

- "Take a Health Professional to the People Day," the Pittsburgh "twist" on "Take a Loved One to the Doctor Day" during which the Center brought health professionals to Black barbershops and beauty salons;

- Health Promotion Sundays in April, an organized effort with churches to disseminate health information; and

- Opening an EXPORT office in the heart of Pittsburgh, an important way to reaffirm the Center's commitment to the community.

Dr. Ruffin thanked all of the guests who presented at the February 2005 Advisory Council meeting, especially the NCMHD grantees for their work to reduce and eliminate health disparities.

NCMHD UPDATE ON INCLUSION OF WOMEN AND MINORITIES IN CLINICAL RESEARCH

Given the need to review funding applications before the day's end, Dr. Kane announced that the Advisory Council would handle this agenda item via email.

CLOSED PORTION - NCMHD

This portion of the meeting was closed to the public in accordance with the determination that it was concerned with matters exempt from mandatory disclosure under Sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2).

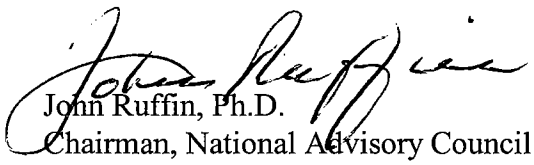
There was a discussion of procedures and policies regarding voting and confidentiality of application materials, committee discussions and recommendations. Members were instructed to absent themselves from the meeting during discussion of applications from their own institutions, or other applications in which there was a potential conflict of interest, real or apparent.

REVIEW OF APPLICATIONS

The Council considered two applications requesting an estimate $500,000 in total costs. Applications that were noncompetitive, unscored, or were not recommended for further consideration by the scientific review groups were not considered by Council. The Council by way of en bloc voting concurred with the first-level peer review on two applications.

Certification

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



John Ruffin, Ph.D.
Chairman, National Advisory Council on Minority Health and Health Disparities
Director, National Center on Minority Health and Health Disparities, NIH

Lisa Evans, J.D.
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