

**Department of Health and Human Services
National Institutes of Health
National Institute of Nursing Research
Minutes of the National Advisory Council for Nursing Research**

May 18-19, 2010

The 71st meeting of the National Advisory Council for Nursing Research (NACNR) was convened on Tuesday, May 18, 2010, at 1:00 p.m. in Wilson Hall, Building 1, National Institutes of Health (NIH), Bethesda, Maryland. The first day of the meeting was an open session and adjourned that same day at approximately 4:48 p.m. The closed session of the meeting, which included consideration of grant applications, was convened on Wednesday, May 19, 2010, at 9:00 a.m. and continued until adjournment at 12:15 p.m. Dr. Patricia A. Grady, Chair, NACNR, presided over both sessions of the meeting.

OPEN SESSION

**I. CALL TO ORDER, OPENING REMARKS, COUNCIL PROCEDURES,
AND RELATED MATTERS**

Dr. Grady called the 71st meeting of the NACNR to order, welcoming all Council members, including new Council members, visitors, and staff.

Conflict of Interest and Confidentiality Statement

Dr. Mary Kerr, Executive Secretary, NACNR, reminded attendees that the standard rules of conflict of interest applied throughout the Council meeting. Briefly, all closed session material is privileged, and all communications from investigators to Council members regarding any actions on applications being considered during the Council should be referred to National Institute of Nursing Research (NINR) staff. In addition, during either the open or the closed session of the meeting, Council members with a conflict of interest with respect to any topics or any application must excuse themselves from the room and sign a statement attesting to their absence during the discussion of that application. Dr. Kerr also reminded NACNR members of their status as special Federal employees while serving on the Council, and that the law prohibits the use of any funds to pay the salary or expenses of any Federal employee to lobby or otherwise influence state legislatures or Congress. Specific policies and procedures were reviewed in more detail at the beginning of the closed session and were available in Council notebooks.

Minutes of Previous NACNR Meeting

Standing Council members received a copy of the minutes of the January 19-20, 2010, NACNR meeting by electronic mail. A motion to accept the minutes of the January 19-20, 2010, Council meeting was proposed, seconded, and approved unanimously. Any comments, corrections, and changes to the January 2010 meeting minutes identified at a later time should be forwarded to Drs. Grady or Kerr. The approved minutes of each quarterly NACNR meeting become part of the Institute's permanent record and are posted on the NINR Web Site (www.ninr.nih.gov).

Dates of Future Council Meetings

Dates of future meetings in 2010 and 2011 have been approved and confirmed. Council members were asked to confirm their calendars for these meeting dates and contact Drs. Grady or Kerr regarding any conflicts or expected absences.

2010

September 14-15 (Tuesday-Wednesday)

2011

January 18-19 (Tuesday-Wednesday)

May 17-18 (Tuesday-Wednesday)

September 20-21 (Tuesday-Wednesday)

2012

January 17-18 (Tuesday-Wednesday)

May 15-16 (Tuesday-Wednesday)

September 18-19 (Tuesday-Wednesday)

II. REPORT OF THE DIRECTOR, NINR—Dr. Patricia Grady, Director, NINR

The Director's report focused on updates since the last Council meeting and on current and impending activities and initiatives related to the NIH and NINR budgets, the NIH overall, and the NINR.

Budget Update—Dr. Grady provided an update on the current status of appropriations and projections for the NINR budget. The NINR's funding for fiscal year (FY) 2010 was \$145.660 million and reflected an increase of 2.7 percent over the FY 2009 level of \$141.879 million. The President's proposed budget for FY 2011 includes \$150.198 million (a 3.2% increase from FY 2010) for the NINR; this proposed amount represents a fiscal landmark for the NINR and offers positive affirmation of research in nursing science. The NIH's overall FY 2010 budget was \$31.008 billion (a 2.3% increase from FY 2009), and the proposed FY 2011 budget is \$32.087 billion (a 3.2% increase from FY 2010).

Dr. Grady reviewed NINR's budget for FY 2009 funds, which included: research program grants (RPGs) (74%), of which P01 grants comprise 1.6 percent; Centers (4%); research management and support (8%); training (6%); research and development (3%); intramural research (3%); and other research (2%). Dr. Grady noted that most of NINR funds are awarded to extramural research grants. The NINR's budget growth from FY 1999 to FY 2010 proportionately mirrors the NIH's increase in appropriations. The NINR's budget has tripled during the past 2 decades, but it remains the third smallest among the NIH Institutes and Centers (ICs).

HHS, NIH, and NINR News—Dr. Grady reported on news items of interest within the Department of Health and Human Services (HHS), NIH, and NINR communities. Drs. Kathleen Sibelius, HHS Secretary, and Francis Collins, NIH Director, were present at President Obama’s signing of the “Patient Protection and Affordable Care Act” into law in March 2010. Provisions in the law that affect the NIH include: enhancements to cost-effectiveness research (CER), designation of the NIH Pain Consortium to recommend Common Fund pain initiatives; creation of the Cures Acceleration Network (CAN), and elevation of the National Center for Minority Health and Health Disparities (NCMHD) to an Institute level.

Dr. Grady informed the Council that the House and Senate Appropriations Committees held NIH overview hearings in April and May 2010. The NIH report on FY 2009 funding for various research, condition, and disease categories (RCDC) covers diseases and conditions that are of particular interest (www.report.nih.gov/rcdc/categories). Dr. Grady presented a brief eulogy for Dr. Ruth L. Kirschstein (1926-2009), an eminent NIH scientist who was instrumental in the establishment of the NINR; in her career, she served as an NIH Deputy Director, Acting NIH Director, and Acting Director of the National Center for Complementary and Alternative Medicine (NCCAM). Dr. Collins has announced that Dr. Harold Varmus will be appointed as the new Director of the National Cancer Institute (NCI); Dr. Varmus is a Nobel Prize winner and previously served as the NIH Director. Drs. Collins, David Botstein, and Eric S. Lander are co-recipients of the Albany Medical Center Prize in Medicine and Biomedical Research. The NINR sponsored a think-tank meeting in April 2010 focused on high-throughput technology, translation

of basic research into beneficial diagnostics and therapeutics, and utilization of science to benefit health care reform. *Parade* magazine featured an article by Dr. Collins on the role of imaging technology to translate science into language that is accessible to lay audiences. The 12th Annual NIH Small Business Innovation Research (SBIR)/Small Business Technology Transfer Research (STTR) Conference will be held in June 2010 to discuss potential science initiatives: The Basic Behavioral and Social Science Opportunity Network (OppNet) is a new trans-NIH initiative, which will expand the Agency's funding of basic behavioral and social sciences research. The Genomic Applications in Practice and Prevention Network (GAPPNet™) provides a means to apply genomics knowledge to prevention efforts. The NIH and the U.S. Food and Drug Administration (FDA) have announced a collaborative initiative intended to fast-track innovations to the public, particularly by accelerating new treatments to patients. The National Library of Medicine (NLM) has launched Mobile MedlinePlus, providing online access to consumer health information through mobile devices. The National Cancer Institute (NCI) is joining the National Institute on Aging's (NIA) efforts in the NIH Senior Health Web Site; the Site now addresses survivorship issues after cancer from a health professional perspective. Dr. Grady encouraged Council members to browse the revamped NIH Office of Extramural Research's Web Site, which employs new technologies and reflects comments received about the Site.

NINR News—Dr. Grady welcomed new NINR Council members, including: Drs. Glenna A. Dowling, Professor and Chair of the Department of Physiological Nursing, Director of the Institute on Aging Research Center, and Associate Director of the John A. Hartford Center of Geriatric Nursing Excellence, University of California at San Francisco, School of Nursing;

Everette J. Freeman, President, Albany State University; Elaine Larson, Associate Dean for Research, Columbia University School of Nursing; and Susan Reinhard, Senior Vice President for Public Policy, AARP, and Director of AARP Public Policy Institute. New staff within the NINR include: Dr. Noreen M. Aziz, Program Director, End-of-Life and Palliative Care Research; and Ms. Crystal Esler, Committee Management Specialist. The NINR has released several requests for applications (RFA) (<http://grants1.nih.gov/grants/guide/index.html>), including: (1) Mechanism, Models, Measurement, and Management in Pain Research; (2) Research on Clinical Decision Making in People With or at Risk for Life-Threatening Illness; and (3) Biobehavioral Methods To Improve Outcomes Research. The *NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights* has provided guidance on the topic through a consensus statement available online. (http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf). The NINR co-sponsored the NIH State-of-the-Science Conference on Preventing Alzheimer's Disease and Cognitive Decline.

NINR Division of Intramural Research—Dr. Grady said that NINR intramural scientists Drs. Wendy Henderson and Hyungsuk Kim discussed their research at the NIH Clinical Center Grand Rounds. Recent publications by intramural scientists cover topics on posttraumatic stress disorder (Gill J et al. *Psychoneuroendocrinol* 2010;35:442-50); hepatitis C progression to hepatocellular carcinoma (Henderson W, Shankar R, and Gill J. *J Viral Hepatitis* 2010;17:59-64); PARP-1 polymorphism and traumatic brain injury (Barr T et al. *J Neurotrauma* 2010;27:465-71); and oral symptoms, QOL, and correlative salivary cytokines in relation to hematopoietic stem cell transplantation (Fall-Dickson J, St. John L, Marden S, Ramsay E. *Biol Blood Marrow Transplant* 2010:Epub).

Dr. Grady informed Council that *The NIH Catalyst* featured a news item on pain research conducted by the NINR intramural program, and she congratulated Dr. Leo Saligan, who received the United States Public Health Service (USPHS) Commendation Medal and USPHS Hasselmeier Award for his leadership and research initiatives. Applications for the BNC Postdoctoral Fellowship in Integrative Medicine are due June 1, 2010. The NINR and Foundation for Advanced Education in the Sciences (FAES) are co-sponsoring a Pains Methodologies Boot Camp on July 19-23, 2010 on the NIH Bethesda campus. Dr. Grady reminded Council that the NINR will celebrate its 25th anniversary at the 2010 Scientific Symposium entitled “Bringing Science to Life” on September 30; she said that Dr. Collins will be the featured speaker on September 29, 2010. Members were invited to visit the NINR Web Site (www.ninr.nih.gov) for additional news.

III. NIH DIRECTOR—Dr. Francis Collins, Director, NIH

Dr. Collins expressed his pleasure in speaking to the NINR and Council. He has appreciated everyone’s support during the past 9 months that he has served as NIH Director. In September 2009, he had the opportunity to tell the NIH story to President Obama and HHS Secretary Sibelius when they visited the NIH campus. Although this Administration clearly believes in science, economic stresses continue, and the NIH leadership is concerned about current and future resources.

Dr. Collins reminded the Council that the NIH has dual roles toward basic and behavioral science—that is, science in pursuit of fundamental knowledge about the nature and behavior of living systems. He congratulated 131 NIH grantees who have won the Nobel Prize, including Dr. Varmus, the upcoming Director of the National Cancer Institute (NCI).

The NIH's understanding of basic science has advanced significantly, as illustrated by advancements in the knowledge of genetic risk factors of disease. Dr. Collins said that very little was known about this topic until 2005, when the NIH began studying the genome and cataloging genetic variations. He illustrated the progression of gene mapping via the GWAS studies from 2005 to the first quarter of 2010. Many organizations have joined the NIH's efforts to understand the gene variant for disease. While most variants have modest ability to identify risk, many point to pathways that may be important for potential drug development.

Dr. Collins said the application of that knowledge helps to extend health life and reduce the burdens of illness and disability. The NIH investment in this translation has made a difference in public health. Longevity in the United States has increased about 1 percent each year for the past 6 years, in large part because of the application of NIH research. In addition, chronic elderly disability has decreased from 27 to 19 percent since 1982. The public and Congress, however, often are unaware of these exciting outcomes.

Several areas continue to need improving, including premature births. An article in the *Journal of the American Medical Association (JAMA)*, January 2010) reported that the March of Dimes report card marked the United States with a grade of "D" for dismal for the more than 540,000

preterm births annually. Dr. Collins observed that the NINR supports the Creating Opportunities for Parent Empowerment (COPE) mechanism, which aims to educate parents of premature infants to improve outcome and reduce hospital expenditures and other health care costs.

Dr. Collins identified major opportunities for NIH research, including: applying high throughput technologies to understand fundamental biology, and to uncover the causes of specific diseases; translating basic science discoveries into new and better treatments; putting science to work for the benefit of health care reform; encouraging a greater focus on global health; and reinvigorating and empowering the biomedical research community.

The NIH traditionally has played a role in the earlier stages of the therapeutic development continuum. Dr. Collins said that advancements in science have allowed the NIH to play a greater role in translation. It is now possible to have an integrated therapeutic pipeline that traverses from disease to: target identified, assay development, HTS, probe to lead, pre-clinical testing, FDA Investigational New Drug Application (IND) submission, Phases 0, 1, 2, and 3, and FDA review. The NIH Molecular Libraries Initiative is involved with assay development, HTS, and probe to lead. The NIH Therapeutics for Rare and Neglected Diseases (TRND) and Rapid Access to Interventional Development (RAID) programs concern preclinical therapy development. The NIH Clinical Center, pharmaceutical and biotechnology industries, and Clinical and Translational Science Awards (CTSAs) are active from the FDA IND submission through all phases of clinical trials and the FDA review. To facilitate the drug pipeline activities, new NIH-FDA partnerships have been established through the NIH FDA Joint Leadership Council, which will improve translational research, make science “regulatory review ready,” and

speed the development of new medical products. Another NIH-FDA partnership is through the Joint Regulatory Science Initiative. A public consultation concerning these partnerships will be held in June 2010.

Dr. Collins described the Cures Acceleration Network (CAN), which was included in the recently passed Health Care Reform Bill. The CAN provides an additional NIH framework for therapeutic agents by dramatically advancing the development of new treatments and cures for debilitating and life-threatening diseases by reducing barriers between laboratory discoveries and clinical trials. The CAN's FY 2010 authorized budget is \$500 million. The program will be situated in the NIH Office of the Director (OD) and will provide flexible funding mechanisms, including grant, partnership, and flexible research awards.

Dr. Collins described the NIH's efforts in cost-effectiveness research (CER), which focuses on disease prevention, diagnosis, treatment, behavior change, health systems, and special populations. The Patient-Centered Outcomes Research Institute (PCORI) is a non-profit corporation mandated by the health care reform legislation to organize and fund CER. Its structure includes a Board of Directors and a standing methodology committee, both with representation from the NIH and Agency for Healthcare Research and Quality (AHRQ). It will identify national research priorities and new clinical evidence and gaps, as well as relevance, standards, and economic correlates. Direct funding appropriations include: FY 2010, \$10 million; FY 2011, \$50 million; FY 2012, \$150 million; and FY 2013-2019, PCORI trust fund, \$150 million plus per capita charge per enrollee per year.

Dr. Collins described the NIH's investment in new, transformative ideas through several mechanisms. The Transformative R01 supports individuals and collaborative investigative teams; there is no budget limit per proposal up to the overall program's budget cap (i.e., \$25 million total costs per year for 5 years). The NIH Director's Pioneer Award supports exceptionally creative scientists and offers a total funding of \$5 million for a 5-year period. The New Innovator Award supports a small number of exceptionally creative new investigators and provides up to \$300,000 in direct costs. The NIH Director's Pathfinder Award To Promote Diversity in the Scientific Workforce funds new approaches to engaging and advancing underrepresented populations (e.g., African Americans, Hispanics, and Native Americans) in scientific programs in academia or the scientific workforce; this American Recovery and Reinvestment Act (ARRA)-funded award provides \$6 million for at least seven awards in FY 2010, with the first awards to be made in July 2010. Dr. Collins also recognized the NINR's commitment to training, including the Graduate Partnerships Program (GPP) and Summers Genetics Institute (SGI), as well as awards for predoctoral, postdoctoral, new investigators, and career researchers.

Dr. Collins said that the FY 2011 President's Budget request totals \$32.2 billion for the NIH. During FY 2003 through FY 2008, the NIH budget struggled with a loss of purchasing power. The majority of the ARRA funds, which were a one-time infusion, were awarded for short-term grants. The NIH success rate in funding grant applications has varied each year but has declined overall since 1979.

Dr. Collins expressed the NIH's commitment to advocating for investment in biomedical research. He encouraged fellow scientists to: educate others about the importance of biomedical research, inspire passion for science in the next generation, contact the NIH with suggestions and comments (NIH-LISTENS@nih.gov), and encourage innovation. Dr. Collins congratulated the NINR on celebrating its 25th anniversary this year and said that he looks forward to attending the official celebration in September.

IV. ECONOMICS RESEARCH AT NIH—Dr. James A. Schuttinga, Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI), NIH Office of the Director

Dr. Schuttinga provided an overview of the NIH economics research portfolio. There are multiple determinants of a health life, which should be addressed through multi-disciplinary research, including the interaction of health and economic well being. In addition, costs matter, and economists have an interest in health and health policy and have developed tools for analysis of observational data and costs.

Dr. Schuttinga reviewed the distribution of primary and secondary funding tiers allocated to economics research across the ICs in FY 2009. Total NIH allocations were \$194 million (primary) and \$74 million (secondary). The top six ICs for primary funding were: National Institute on Aging (NIA), \$79 million; the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), \$29 million; NCI, \$20 million; NIMH, \$20 million; National Institute on Drug Abuse (NIDA), \$9 million; and NINR, \$9 million. Institutes supporting economics research through Tier 2 awards included: the National Institute of

Diabetes and Digestive and Kidney Diseases (NIDDK), \$34 million; NIDA, \$27 million; National Heart, Lung and Blood Institute (NHLBI), \$9 million; and NCI, \$2 million. The total NIH primary allocations in economics also were captured in selected Research, Condition, and Disease Categorization (RCDC) categories: behavioral and social science, burden of illness, clinical trials, comparative effectiveness, cost effectiveness, health services, and nutrition.

Major categories of economics research at the NIH encompass: economics status, health, and well-being over the life course and across generations, including child development (\$86.5 million); costs and benefits of interventions, including clinical and community health (\$39 million), insurance design and health system performance (\$36.7 million), and non-health public policy (\$11.7 million); and analyses, data, and methods to support the examination of health interventions (\$20.7 million). The NINR promotes economic research by supporting studies on the entry and retention of women in the sciences; fatigue self-management in primary care; health benefits and cost of human milk feedings for very low birth weight infants; and cost effectiveness of rural breast cancer survivors and of heart failure patients with diabetes. Other NINR-supported studies include: incentives and organization for health care delivery, such as distribution of the costs of antimicrobial resistant infections and multilevel interventions to improve nursing home outcomes; and methodology to examine health interventions, such as Center for Evidence-based Practice in the Underserved (CEBP) and methods and statistical core to build the science of self-management from a systems approach.

Alternative dimensions of NIH economics study include research to improve decisionmaking (\$12.8 million – \$194 million), primary data collection (\$102.5 million), disparities and

disadvantaged populations (\$74.3 million), international/global scope (\$16.4 million), and training (\$10.2 million). Approaches to research for better decisionmaking include: neoclassical economics (“rational consumer”); behavioral economics (psychology plus economics); and neuroeconomics, (behavioral economics plus observation of the nervous system). Dr. Schuttinga said that the first step toward analysis of an economics portfolio is identifying: what must be known, what is being done what other organizations are funding, and what research remains to be addressed.

V. COST-EFFECTIVENESS ANALYSIS IN QUALITY OF LIFE RESEARCH—

Dr. Patrick McNees, Professor, School of Nursing, and Professor and Associate Dean for Research, School of Health Professions, University of Alabama at Birmingham

Dr. McNees presented a study of the cost effectiveness of the rural breast cancer survivor intervention package, which was conducted with co-Principal Investigators (co-PIs) Drs. McNees and Karen Meneses, Professor and Associate Dean for Research, School of Nursing, University of Alabama at Birmingham. It incorporates cost-effectiveness analysis into factors affecting quality-of-life (QOL) health-related research and particularly aims to make a meaningful difference in the QOL of breast cancer survivors. With 10.8 million cancer survivors in the United States, who represent 3.7 percent of the population, cancer survivorship research is important. Intervention research to prevent and control adverse outcomes (e.g., late effects of treatment, second cancers, and poor QOL) also is relevant. Four activities focus on intervention research with breast cancer survivors: Breast Cancer Education Intervention (BCEI), Rural

Breast Cancer Survivor Intervention (RBCS), Cost-Effectiveness of the RBCS Intervention Package, and Fertility and Cancer Project (FCP).

Dr. McNees described a study to determine the efficacy of the BCEI on QOL by examining the physical, psychological, and spiritual well being of patients who shared equivalent demographics and treatment characteristics. The study found that BCEI was effective in maintaining and improving QOL in breast cancer survivors and that QOL effects were sustained over time. BCEI required in-person contact, and at-risk groups, such as rural residents (distance barrier) and Spanish speakers (language barrier) were less likely to participate. In addition, the effects of the BCEI intervention were found to be similar for both urban and rural breast cancer survivors.

Telephone-supported feasibility was tested on a sample of women and found that, if reached, participants discussed issues freely. Because telephone-mediated supported appeared feasible, it was used in the RBCS, which provided education information tailored to a woman's specific, perceived need. The RBCS intervention considered the physical, psychological, and spiritual well being of patients. More than 225 patients are enrolled, and early observations indicate that older and poorer patients suffer from greater comorbidities. Cost effectiveness of RBCS was examined to determine: (1) the effects of the RBCS intervention on QOL and QOL-adjusted life years; (2) the cost of implementing the RBCS intervention package; (3) the impact of participating in the RBCS; and (4) the incremental cost-effectiveness ratio of the RBCS compared to usual care. A cost comparative analysis and cost of intervention will be conducted to determine the cost of the intervention for the research and the cost of participation for the research subject. The study has initiated recruitment, enrollment, and attrition phases;

responsiveness to mailings and telephone follow up is approximately 9 percent, compared to a normal 2 percent at this stage of the study. In addition, no substantial barriers to addressing study aims have been detected. The study should be able to calculate return on investment for various recruitment efforts as well as formulate sustainable service model. The study is employing new tools and methods, including: CuSum, an engineering model to handle variable data to determine recruitment and enrollment patterns; the LIITE index; the Florida Index of Treatment Access (FITA); and value weight return on investment (vw ROI).

VI. DIVISION OF EXTRAMURAL ACTIVITIES: HEALTH PROMOTION AND DISEASE PREVENTION UPDATE—Dr. Karen Huss, Program Director, NINR

Dr. Huss provided an update of the NINR's Division of Extramural Activities (DEA) efforts in cost-effectiveness research (CER) in the context of health promotion and disease prevention. Cost-effectiveness analysis, which is used in health services, is a form of economic analysis that compares the relative costs and outcomes (effects) of two or more courses of action. The most commonly used outcome measure is quality-adjusted life years. The NIH initiated CER in 1993 with a panel on Cost Effectiveness in Health and Medicine. Additional NIH and NINR workshops and activities on CER included: a cost-effectiveness analysis in research workshop in 2004; a workshop on integrating cost-effective analysis in clinical research in 2008; and an economic analysis of nutrition interventions in 2010.

The NINR has supported CER and health promotion and disease prevention studies, including the COPE intervention on reduced NICU and hospital length of stay. Other NINR studies have

shown that disease management programs reduce costs and that diabetes self management is cost effective.

Ongoing NINR-funded studies addressing CER and health promotion and disease prevention focus on integrating cost effectiveness analysis into factors affecting QOL health-related research. Specific research includes: cost effectiveness and QOL in heart failure patients with diabetes; health-related QOL impacts of illness on family and caregivers; tools for economic analysis of patient management interventions in heart failure; and cost effectiveness of the RBCS intervention package. NINR-supported training studies are: identifying interventions to improve outcomes of patients with cancer and applying cost-effective analysis to evaluate economic outcomes in Magnet and non-Magnet hospitals; employing methods and statistics with an emphasis on economic analysis to conduct cost analysis in descriptive studies and cost utility analysis in intervention studies; and applying methods to analyze cost to payers using claims data. ARRA funds were awarded to CER studies in clinical research, technology and methods, and training.

Priorities for CER in the future include: support multidisciplinary CER and health promotion and disease prevention; integrate clinical and administrative data; design economic evaluation projects to examine costs and long-term outcomes; increase emphasis on modeling; enhance dissemination and translation of CER and health promotion and disease prevention; and standardize costs across studies. Other steps are to partner with the Centers for Disease Control and Prevention (CDC) and Agency for Healthcare Research and Quality (AHRQ) to evaluate interventions in CER and health promotion and disease prevention, develop economic studies to

inform resource allocation, and increase cost-effective analysis career development and Center research.

Following this update, Dr. Grady thanked participants and attendees for their time and interest and adjourned the open session of the meeting.

CLOSED SESSION

This portion of the meeting was closed to the public in accordance with the determination that this session 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, USC Appendix 2). Members absented themselves from the meeting during discussion of and voting on applications from their own institutions or other applications in which there was a potential conflict of interest, real or apparent. Members were asked to sign a statement to this effect.

REVIEW OF APPLICATIONS

The members of the NACNR considered 110 research and training grant applications on which NINR was the primary Institute; these applications requested a total of \$28,317,873 (direct costs year 01). The Council also considered 559 applications on which another Institute/Center was primary and NINR was secondary; these applications requested a total of \$167,347,674 (direct costs year 01). The Council concurred with the IRG recommendations on these 669 applications.

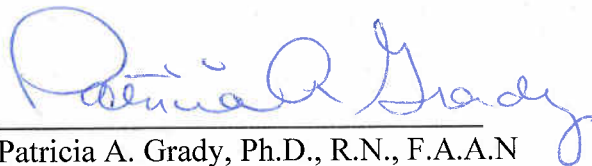
The members of the NACNR also considered 25 American Recovery and Reinvestment Act 5 applications on which NINR was the primary Institute; these applications requested a total of \$709,160 (direct costs). The Council concurred with the IRG recommendations on these 30 applications, including supplements.

ADJOURNMENT

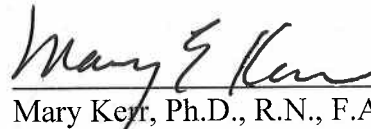
The 71st meeting of the NACNR was adjourned at 12:15 p.m. on May 19, 2010.

CERTIFICATION

I hereby certify that the foregoing minutes are accurate and complete.



Patricia A. Grady, Ph.D., R.N., F.A.A.N
Chair
National Advisory Council for Nursing
Research



Mary Kerr, Ph.D., R.N., F.A.A.N.
Executive Secretary
National Advisory Council for Nursing
Research

MEMBERS PRESENT

Dr. Patricia A. Grady, Chair
Dr. Mary E. Kerr, Executive Secretary
Dr. Anna Alt-White, *Ex Officio*
Dr. Marion Broome
Dr. Glenna Dowling
Dr. Stan Finkelstein
Dr. Everette Freeman
Dr. Kevin Frick
Dr. Diana Lake
Dr. Elaine Larson
Dr. Jean McSweeney
Dr. Kathleen Potempa
Capt. Maggie Richard, *Ex Officio*
Dr. Gail Stuart
Dr. King Udall
Dr. Janet Williams

MEMBERS OF THE PUBLIC PRESENT

Corina Barrow, Senator Inouye's Office
Suzanne Begeny, American Association of Colleges of Nursing
Dr. Sharron J. Crowder, Indiana University School of Nursing
Dr. Patrick McNeese, University of Alabama at Birmingham
Christine Murphy, National League of Nurses
Ukamaka Oruche, Indiana University School of Nursing
Darlene Summers, Consolidated Solutions and Innovations

FEDERAL EMPLOYEES PRESENT

Mr. Brian Albertini, NINR/NIH
Dr. Noreen Aziz, NINR/NIH
Dr. David Banks, NINR/NIH
Ms. Melissa Barrett, NINR/NIH
Mr. Brian Beckham, NINR/NIH
Mr. Raymond Bingham, NINR/NIH
Dr. Yvonne Bryan, NINR/NIH
Ms. Andria Cimino, NINR/NIH
Dr. Paul Cotton, NINR/NIH
Ms. Lisa Depaolo, NINR/NIH
Dr. Ray Dionne, NINR/NIH
Ms. Crystal Esler, NINR/NIH
Dr. Chris Hafner-Eaton, NINR/NIH
Ms. Ana Ferreira, NINR/NIH
Ms. Linda Fitzwater, NINR/NIH
Dr. John Grason, NINR/NIH
Dr. Kevin Green, NINR/NIH
Dr. Amanda Greene, NINR/NIH

Dr. Wendy Henderson, NINR/NIH
Dr. Jeanette Hosseini, NINR/NIH
Dr. Karen Huss, NINR/NIH
Mr. Douglas Hussey, NINR/NIH
Ms. Deborah Jennings, NINR/NIH
Ms. Ellie Johnson, NINR/NIH
Dr. Weiqun Li, NINR/NIH
Dr. Yujing Liu, NINR/NIH
Dr. Susan Marden, NINR/NIH
Ms. Angela Marshall, NINR/NIH
Dr. Arthur Meltzer, NINR/NIH
Dr. Jeri Miller, NINR/NIH
Ms. Sussana Morales, NINR/NIH
Ms. Mary Murray, NINR/NIH
Ms. Brandis O'Neal, NINR/NIH
Dr. Natalie Rasmussen, NINR/NIH
Dr. Mario Rinaudo, NINR/NIH
Mr. Chip Rose, NINR/NIH
Dr. Denise Russo, NINR/NIH
Dr. James Schuttinga, NINR/NIH
Ms. Candice Scott, NINR/NIH
Ms. Cheryl Stevens, NINR/NIH
Dr. Xenia Tigno, NINR/NIH
Dr. Lois Tully, NINR/NIH
Dr. Joan Wasserman, NINR/NIH
Dr. Linda Weglicki, NINR/NIH
Mr. Max Whitfield, NINR/NIH
Ms. Laura Williams, NINR/NIH