| Response to NOD-07-074 |
| The NIH Peer Review Process |

These comments are being submitted by Kristine Wong (kristine@u.washington.edu) on behalf of a group listed below

1. Challenges of NIH System of Research Support

<u>Guiding principles and priorities</u>
We urge NIH to embrace Dr. Zerhouni's strategy of the 4th "P," which stands for "Participatory"- along with "Predictive," "Preemptive," and "Personalized" as the guiding principles to transform the clinical research enterprise at NIH.   In particular, we urge NIH to embrace community-based participatory research (CBPR) as a strategy both for engaging communities as partners in the research process, and for increasing the quality and impact of research.   CBPR is "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change..." (Kellogg Community Health Scholars Program, 2001 – see references below). Research involving communities as equal partners (i.e., in determining the research question and methods, implementing the research, disseminating and translating results into practice and policy) not only increases the validity and rigor of the data collected, but also builds capacity in communities to work on the issues affecting them. (To learn more about CBPR, please visit Community-Campus Partnerships for Health's in-depth CBPR resource webpage at http://depts.washington.edu/ccph/commbas.html, and the online CBPR curriculum available at www.cbprcurriculum.info).

NIH does fund CBPR, and in the past few years has issued a number of announcements that specifically request CBPR proposals (e.g., PAR-05-026 Community Participation in Research, RFA-MD-05-002 Community Participation in Health Disparities Intervention Research, RFA-HL-06-002 Community-Responsive Interventions to Reduce Cardiovascular Risk in American Indians and Alaska Natives). However, its overall investment in CBPR has been quite modest and we believe should be substantially increased. A CRISP database search using the term CBPR, for example, yields 84 "hits" for the period 2000-2006 (by comparison, a similar search using the term RCT yields 716 "hits"). Further, there are many opportunities to apply CBPR principles and approaches in clinical and translational research. For example, Community-Campus Partnerships for Health (www.ccph.info) and the Education Network to Advance Cancer Clinical Trials (www.enacct.org) just this week sponsored the first of a three-part conference series, "Communities as Partners in Cancer Clinical Trials: Changing Research, Practice and Policy" that is generating a strategic plan for how to do so in the context of cancer clinical trials (with core funding from AHRQ and NCI, R13 HS16471).

Definition of eligible applicant organization and principal investigator
We support the regulations proposed by NIH in the June 25, 2007 Federal Register regarding (1) the expansion of the agency's definition of PI (from allowing just one investigator to serve as PI on a research grant, to multiple PIs) and (2) the expansion of the number of awards that can be made from a single application from one award to multiple awards. We believe that these changes will contribute towards greater accountability and equality between community and institutional partners working together on CBPR grants. We hope that you will take the further step to ensure equality and accountability at the highest levels by allowing, encouraging and supporting qualified individuals from community partner organizations without doctoral or medical degrees to also serve as PIs.

To fully embrace CBPR, NIH needs to reconsider and revise the definitions and eligibility criteria for applicant organizations and Principal Investigators (PIs) in order to facilitate the eligibility of community-based researchers, including those affiliated with community-based organizations (CBOs), to apply and successfully compete for NIH grants. With few exceptions (e.g., the National Center for Minority Health and Health Disparities CBPR funding stream), very few NIH funding announcements support individuals without doctoral or medical degrees to be PIs. It is not enough to point to eligibility criteria on paper that indicate that community and faith-based organizations can apply for NIH grants. The reality is that few apply and even fewer are funded.

Investments must be made in building the capacity of these organizations to be successful, just as investments are made in faculty members and academic institutions. NIH research resources need to be dedicated to train community members to serve as PIs, Co-PIs and as researchers. There are a number of ways to approach this, including (a) developing structured mentoring and pipeline programs where established academic PIs who are skilled in CBPR could train people from CBOs; (b) offering training workshops for community partners on research methods, grant writing and grant administration; and (c) providing grant funding to CBOs to develop their research capacity by creating a cohort of individuals interested in developing themselves as CBPR researchers in community settings (similar to the Robert Wood Johnson Clinical Scholars Program and the Kellogg Health Scholars Program for CBPR researches in academic settings). There are a number of funding agencies that serve as models for awarding research grants to CBOs and building community research capacity, including the California Breast Cancer Research Program, the Northwest Health Foundation, the Paso del Norte Health Foundation (though the Center for Border Health Research), the Ontario HIV Treatment Network, and the Canadian Institutes of Health Research.

We also support the proposed change regarding multiple awards, as it provides greater sovereignty for the community partner over its budget, compared to the limited control it has in the current predominant model in which the community partner serves as a subcontractor to the funded organization and its PI.

Finally, we ask that you identify and report annually on: mechanisms in place at NIH to ensure that CBOs have opportunities to access NIH funding, the number and dollar

amount of grants that incorporate a CBPR approach, and the number and dollar amount of grants that have a CBO grantee/principal investigator. CBO should be its own category in the NIH report on funding by institution type in the report on NIH support by type of institution (http://grants.nih.gov/grants/award/trends/instchar05rg.htm).

Current array and duration of grant mechanisms
We strongly believe that there need to be NIH grant mechanisms that explicitly build the infrastructure and capacity for community-based participatory research (CBPR), as well as to conduct CBPR.

For CBPR grants, the usual NIH funding period (2-5 years) is not long enough to develop the authentic partnership that comprises the foundation for CBPR *and* conduct research that involves the community as an equal partner. Because NIH rarely awards research planning grants, there is a good chance that new CBPR partnerships funded by NIH will not have the time to establish the key elements needed to achieve equal partnerships (community-based organizations and academic researchers are rarely are able to devote time to a project that they do not have funding for; in addition, most university researchers seeking tenure are not advised to do CBPR work, based on the extra amount of time it takes to publish results vs. the time it takes to publish traditional research results). One good example of an NIH program that has taken steps to address this issue is the CBPR funding stream created by the National Center for Minority Health and Health Disparities (NCMHD). Recognizing the time and relationship-building required by high-quality CBPR, NCMHD first announced 3-year planning grants to develop equal partnerships (RFA-MD-05-002), followed by 5-year implementation grants (upon demonstrating that the planning period has resulted in an emerging authentic partnership) (RFA-MD-07-003), and planned dissemination grants.

Number of grants awarded per investigator
NIH funding mechanisms that limit submissions to only one per institution not only creates a competitive environment among researchers within a given institution, but also suppresses new and innovative work from being considered (due to the fact that institutions tend to select the application it estimates has the highest probability of being funded). This limitation also poses difficulties for community partners, who may be working with a number of researchers within a given institution on different research projects and are beholden to the institution's decision about which researcher is allowed to apply. We recommend that this requirement be eliminated for the purpose of stimulating a thriving, vibrant, and collaborative community of researchers across the country, while allowing flexibility and the possibility of more than one community health priority to be addressed.

Geographic considerations when awarding grants
We believe that NIH takes into consideration all other currently funded projects in the applicant's geographic region before deciding which projects will receive funding. We believe that whether or not an application gets funded should be based on its merit, and not penalized simply because there are other investigators in the region who have received NIH funding.

2. Challenges of NIH Peer Review Process – and Recommended Solutions

The challenge: Lack of transparency. Significant challenges are posed by the lack of transparency about the NIH peer review process. Unless one is deeply entrenched in the NIH process (as an NIH staff member or an established NIH-funded investigator, for example) the peer review process at NIH is difficult to navigate and understand. In the words of a community leader who participated in a summit on community-higher education partnerships, "NIH is an exclusive club. The walls around it are impenetrable to community people." This clearly needs to change.

Much is not known about how the NIH peer review process actually plays out in practice. For example, the second-level review conducted by the National Advisory Councils of each Institute and Center is not transparent, and does not consistently apply standard criteria to how applicants will be selected for funding. It is also not clear how Council members are identified and selected.

The solution: Create transparency around all peer review processes and decisions. Each applicant should receive a letter detailing their proposal's evaluation results at each level of the peer review process. This process should also be clearly explained on the NIH website, as well as how the National Advisory Council members are identified and selected. There needs to be an open and transparent process for Council membership. Further, a thorough evaluation of the peer review process by an independent third party (such as the Government Accountability Office) is needed to ensure that the current review process is fair, to identify discrepancies between policy and practice, to identify areas of improvement and to make recommendations for improvement.

Defining "peer" in peer review

The challenge: NIH seems to define "peer" in peer review as a doctoral-level researcher. In CBPR, and in clinical and translational research in particular, "peer" needs to be re-defined to include the partners engaged in the research. This includes, for example, individuals within community-based organizations, and community health centers who are engaged in research but may not necessarily have doctoral degrees or have published in the traditional realm of peer-reviewed journals. NIH needs to explicitly define what it means by "peer" in peer review and make it more welcoming and inviting to community members to serve as reviewers. Funding announcements do not clearly communicate whether or not community-based individuals are eligible to serve as a peer reviewer, and do not explicitly state the value of having peer reviewers that have experienced and observed health disparities in their own communities. As a result, announcements do not make it clear to community-based individuals about how they can participate.

The solution: clarify key terms: The language NIH uses to define and describe peer review should be clear and consistent (so that applicants, peer reviewers, and potential peer reviewers are "on the same page" as to what is meant by certain terms). For example, there may be an assumption that the definition and use of the term "peer" in the context of "peer review" and "principal investigator" in the context of research are

commonly known, but in fact, many community-based individuals are unclear as to what these terms mean. Moreover, among those who are familiar with the term "peer reviewer," many without advanced degrees do not feel they qualify to be a peer reviewer. Defining the qualifications, duties, and responsibilities of a peer reviewer is necessary if NIH hopes to truly develop a peer review process that fully embodies their core values, with the most appropriate individuals reviewing the diverse types of grants in their portfolio.

Identifying and selecting reviewers
The challenge: It is unclear how one can become a peer reviewer. The process should be an open one with clear eligibility criteria and priorities, where individuals may indicate their interest and apply to be a reviewer. Many federal agencies have widely publicized, open calls for reviewers, with online applications that are easy to understand and use (e.g., the U.S. Department of Housing and Urban Development's Office of University Partnerships, the Corporation for National and Community Service, the Health Resources and Services Administration). NIH should do the same. In particular, NIH needs a clear and succinct communication strategy that will reach community-based organizations with information about how to become a peer reviewer.

The solution: greater outreach and publicity to recruit peer reviewers from the community: NIH needs to openly and widely communicate a process for identifying and recruiting peer reviewers, especially from community-based settings. These communications need to be distributed in venues that will truly reach a large percentage of community-based individuals, such as targeted mailings to PIs of CBPR grants (not only those funded by NIH, but also CDC and private foundations) and community-based organizations. This will require partnerships with organizations that represent and serve these constituencies, such as those listed at the end of these comments.

Ensuring reviewers are prepared for their role
The challenge: The current peer review process does not prepare peer reviewers properly for their role. This hinders the process of fostering the diverse group of peer reviewers needed in order to truly have a "peer" review process. Training and mentoring are needed. Based on the NIH peer review experience of those submitting this statement, when CBPR grants were being reviewed in a particular study section, there was no training provided on the principles and definition of CBPR, and it was obvious that some reviewers assigned to CBPR applications had no understanding of CBPR.

The solution: provide training for peer reviewers: Peer reviewers should be provided guidance and training in general topics pertaining to NIH peer review (e.g., conflict of interest, standard review criteria, role of primary and secondary reviewer, scoring) and in specific topics that pertain to the particular review (e.g., for the substantive focus of the funding announcement such as CBPR, as well as any special review criteria). These trainings can be administered via teleconference call and should occur well in advance of starting the actual review. Having an orientation or training session at the start of the in-person review meeting is too late in the process for the information to be

comprehensively understood and applied by reviewers. For standing study sections, links should be provided for web-based materials between study section meetings.

<u>Composition of study section and review panels</u>
The challenge: Study sections and review panels rarely contain an equitable number of people from the diverse communities reflected in the research being proposed. The Community-Level Health Promotion Study Section, for example, has no community-based peer reviewers. It is crucial that CBPR applications and applications in response to PAs and RFAs that expect significant community engagement components be peer reviewed by peer reviewers from the community who have knowledge, experience and expertise in CBPR, community engagement and community-institutional partnerships.

When community-based people serve as peer reviewers, they are usually outnumbered by those from the academic research community and can feel intimidated by this imbalance. As a result, some may not vocalize their true feelings and opinions during the meeting, which hinders a fair and unbiased process. NIH needs to be cognizant of this power dynamic that often takes place, and take steps to address it.

The solution: We recommend that a standing study section be formed to review CBPR proposals. This section should be comprised of an equal number of academics and community members with CBPR experience and expertise who have been properly prepared, and led by designated community-based and academic-based co-chairs. All NIH funding announcements that include a community engagement component (e.g., the Clinical and Translational Research Awards) should recruit peer reviewers with experience in community engagement and CBPR, including community-based reviewers. Review panels should be assembled that include researchers and community partners with experience and expertise in the content area and in CBPR.

<u>Limitations of the review criteria</u>
The challenge: Even if reviewers are trained in CBPR, the standard NIH peer review criteria are based on a biomedical research model, rather than a CBPR model.

The solution: incorporate criteria that are appropriate for CBPR: see answer to question 4 below.

<u>From peer review to research outcomes and results</u>
The challenge: A review is also needed of the outcomes of the peer review process – in other words, a review of the research that is funded by NIH.   To what extent, for example, has NIH-funded research had a significant or beneficial impact on health disparities, and the communities that suffer from these disparities?

The solution: Evaluate funded grants over the last 10 years to assess their impact on health disparities.

Lack of sufficient internal expertise in CBPR
The challenge: If appropriate CBPR peer review criteria and processes are to be developed by NIH, it is absolutely necessary that NIH acquire staff with knowledge and expertise in this area, in order to shepherd the process.

The solution: Develop a strategic plan that incorporates a wide range of strategies to recruit and retain staff with expertise in CBPR. This strategic plan must include a timeline detailing the steps to achieve the goal of hiring a specific number of staff with CBPR knowledge and expertise to be hired in each Institute and Center, using benchmarks to monitor progress and reach intermittent goals. Those with sufficient "knowledge and expertise" should be evaluated through their familiarity and comfort level with CBPR and community engagement, as well as existing tools, curriculum, literature, and materials developed by community and academic partners engaged in CBPR activities.

3. Core Values of the NIH Peer Review Process:

We believe in maintaining, enhancing, and extending the core values espoused by NIH (objectivity, fairness, absence of bias, high ethical standards) to make them applicable to CBPR grant applications. Simply put, these core values are often undermined when it comes to the peer review of CBPR applications. We believe it is unfair and unethical for NIH to consider CBPR applications utilizing the peer review process as it is currently constructed. Within the current framework of peer review, it is difficult for CBPR applications (including community-based applicants and the community partners working as part of the research teams in these applications) to (1) be evaluated on appropriate standards, and (2) be evaluated by their peers (since the great majority of "peer" reviewers have been trained in the basic sciences and traditional research approaches, do not have a community background, or CBPR training or expertise). This imbalance can result in a bias against CBPR projects, in that most peer reviewers are not familiar with CBPR and value doctoral degrees over PhDs "from the street" (those with expertise in their community's experience, culture, assets, and priorities through living and/or working there). This bias can result in CBPR grants not being assessed as "rigorous enough" to qualify for NIH funding, or having a weak methodology, when in reality, involving the community to ensure that the research question is designed and implemented in a way that is both important and appropriate for their community (a "community-based" study) can create data that is even more credible than those studies that did not use a CBPR approach, yet administered a study in the community (a "community-placed" study). Review panel members should be encouraged to discuss the relative strengths and weaknesses of conventional research approaches (such as randomized controlled trials) against modifications that are more responsive to community concerns (such as delayed intervention controls).

We recommend that NIH publicize these core values on their website and all funding announcements, as it is difficult for the general public to know what these are: a search of the NIH website of the term "core values Peer Review" turned up very little information.

Rather than being listed prominently on a page for quick reference on NIH's Office of Extramural Research's home page for Peer Review Policies and Practices (http://grants.nih.gov/grants/peer/peer.htm) as they should be, they were hidden in a few assorted PowerPoint presentations that seemed to be created for a meeting presentation, and within a text-heavy summary of an NIH Internal Consultation meeting. The core values themselves were not even listed in the text of this question (#3), despite the fact that one was asked to give input on which should be "maintained or enhanced"!

4. Peer Review Criteria and Scoring

Review Criteria
CBPR applications are not being reviewed using appropriate criteria. We recommend changing the review criteria for CBPR proposals. For example: Reviewers are asked to review proposals based on "scientific and technical merit," but in the CBPR approach to research, scientific and technical merit also includes taking into consideration the sociopolitical factors between community and institutional partners, such as: whether the partnership has taken the time to develop equal decision making structures and procedures in all phases of the study, whether there is a mechanism for two-way accountability built into the partnership, and whether there is an indication that the partnership is based on a high level of communication and trust working towards common goals. In other words, the review criteria need to explicitly include an assessment of the level of authentic partnership between the institution and the community. This can be assessed by establishing review criteria that scores the level of authentic community partnership/engagement through indicators such as: equitable distribution of budget, presence of a community Co-PI, and a history of partnership activities and outcomes that are meaningful to all partners. As a result, reviewers would be using a wide variety of standards to judge community partnership for CBPR proposals.

We encourage NIH to consider the peer review criteria and guidelines advanced by the AHRQ evidence report on CBPR (see: http://depts.washington.edu/ccph/pdf_files/CBPR_rev_app_guide.pdf and http://depts.washington.edu/ccph/pdf_files/CBPR_rev_check.pdf) In fact, the NCMHD has already adapted them for use in its CBPR funding announcement (see http://grants.nih.gov/grants/guide/rfa-files/rfa-md-07-003.html and below):

"Special guidelines for the review of CBPR applications include the applicant's ability to incorporate the following elements:

Significance. Does this study address an important problem? If the aims of the application are achieved, how will scientific knowledge or clinical practice be advanced? What will be the effect of these studies on the concepts, methods, technologies, treatments, services, or preventative interventions that drive this field?
- What is the potential impact of the study on reducing health disparities through increased knowledge, behavioral and/or social change resulting from the community partnership?

- How will applicant convey the perceived importance and relevance of the research questions and proposed study to community partners, and thus, the likelihood for increased buy-in and participation?
- Does this study contribute to translational research?

Approach. Are the CBPR logic model or conceptual framework, design, methods, and analyses adequately developed, well integrated, well reasoned, and appropriate to the aims of the project? Does the applicant acknowledge potential problem areas and consider alternative tactics?
- How will the community be involved in all phases of the research effort (conceptualization, design, methods and analysis)?
- Does the applicant present strong arguments for the proposed study design as the best possible balance of scientific rigor, implementation constraints and ethical treatment of community partners?
- Does the applicant present the design of a rigorous process and outcome evaluation?
- Does the applicant provide a convincing rationale and adequate plan for how the community partnership is expected to enhance recruitment, retention, measurement design, data collection, and analysis/interpretation?
- Is there an adequate plan for facilitating dissemination and translation of study findings through the CBPR process?
- Are the potential limitations of the study design and CBPR approach adequately addressed?

Innovation. Is the project original and innovative? For example: Does the project challenge existing paradigms or clinical practice; address an innovative hypothesis or critical barrier to progress in the field? Does the project develop or employ novel concepts, approaches, methodologies, tools, or technologies for this area?
- Does the applicant adequately describe how innovative ideas resulted from community participation in developing the research questions, methods, and/or intervention approaches?
- Does the applicant adequately discuss how community input generated innovative approaches to overcoming research challenges?

Investigators. Are the investigators appropriately trained and well suited to carry out this work? Is the work proposed appropriate to the experience level of the principal investigator and other researchers? Does the investigative team bring complementary and integrated expertise to the project (if applicable)?
- Does the applicant provide information indicating that the training, qualifications, experience and commitment of the investigators are appropriate and well suited to the project?
- Do the investigators have prior CBPR training and experience?
- Does the applicant indicate the degree to which and in what way university and community partners have collaborated in the past?
- Does the applicant describe the way in which community partners will be assured "a place at the table"?

- Does the applicant describe the specific expertise and strengths to be contributed by the community partners?
- Does the applicant adequately describe the community advisory board which has guided the design and conduct of the study?

Environment. Does the scientific environment in which the work will be done contribute to the probability of success? Do the proposed studies benefit from unique features of the scientific environment, or subject populations, or employ useful collaborative arrangements? Is there evidence of institutional support?
- Does the applicant provide credible evidence of institutional and community support through letters or memorandum of agreement (MOA) or understanding (MOU), and descriptions of prior collaboration?

Translation
- Will the proposed study apply evidence-based research in the community setting to translate research findings into practice?
- Will the CBPR approach in the study enhance the potential for dissemination of research findings and long-term sustainability of positive community practices?"

Scoring
The NIH scoring system (i.e., the lower the score, the stronger the application) is counterintuitive; as a result, many first-time reviewers may inadvertently assign the wrong score to proposals. To avoid this from happening, we recommend that special care be taken in orienting new reviewers and applicants to this system.

NIH applications are given one overall priority score. We recommend that a score also be assigned to each of the review criteria (i.e., significance, approach, innovation, etc.) in order to ensure that reviewers are adequately attending to each criteria, to better inform the discussion during the review meeting, and to better inform the triage process. Currently, the triage process uses the average overall priority score to determine whether or not an application should be discussed at the in-person review meeting. By having reviewers assign a score to each of the review criteria, and then sharing the scores with all peer reviewers, each reviewer will have greater insight into all of the applications, including those for which s/he was not assigned as a reviewer. Scoring each individual review criteria allows reviewers to discuss the strengths and weaknesses of the "marginal" grants on a more substantive and objective level. A reviewer would also have more objective justification for asking that a triaged application be discussed. Sharing these scores with applicants would also increase the core values of "objectivity" and "fairness" in the NIH peer review system.

Under current NIH review considerations, reviewers are asked to assess "the reasonableness of the proposed budget and the requested period of support in relation to the proposed research," but the priority score may not be affected by the evaluation of the budget. We believe reviewers should be provided with criteria for assessing the budget, and the assessment of the budget should be considered in the scoring. The level of

funding requested and how it is distributed is an important indication of the quality and feasibility of the proposed research. In CBPR, for example, one would expect to see the budget distributed among the partners involved in the research in relation to their roles and responsibilities, along with a commitment to build capacity among partners. See the budget review criteria proposed in the AHRQ evidence report on CBPR http://depts.washington.edu/ccph/pdf_files/CBPR_rev_app_guide.pdf, http://depts.washington.edu/ccph/pdf_files/CBPR_rev_check.pdf and below:

- "Discuss how direct costs are consistent with the proposed methods, specific aims, and CBPR approach.
- Provide good documentation for compensation to study participants and community partners in terms of ethical rationale and enhanced recruitment, retention, and participation.
- Provide justification for resources applied to enhancing the research capacity of community members (such as interviewer training) while improving your response rate.
- Provide justification for infrastructure support to community organizations.
- Create a mechanism whereby community organization can serve as the lead fiduciary agency."

 "Budget and Timeline
- Reflects the resources and time needed to develop or enhance community partnerships.
- Includes resources and a strong rationale for expenses related to recruitment, retention, and partnership building while respecting the cost of research to participants and community partners (food, travel, lodging, meeting room rental, office supplies for community-based research staff, reimbursement or incentives for lay health advisors).
- Includes and justifies the cost of training and materials to institutionalize interventions or initiate efforts by the community to address policy and environmental change as a result of research findings."

5. Career Pathways

We believe it is important for NIH to review applications from new investigators, investigators from new applicant organizations, and investigators from community-based organizations differently than those from experienced investigators and applicant organizations. Review criteria and scoring procedures must be developed and applied uniformly. For example, applications submitted by investigators who are new to NIH are supposed to be considered differently from those submitted by established investigators. However, the criteria used to review applications submitted by new investigators are not clear and we are concerned that they are not uniformly applied. The NIH website (http://grants.nih.gov/grants/new_investigators/resources.htm) indicates that "Peer reviewers are instructed to focus more on the proposed approach than on the track record, and to expect less preliminary data than would be provided by an established

investigator." We recommend that each of these review categories be made explicit and assigned a score (see our comments under "Scoring" above).

For any investigator submitting an R, K, T, or F application that involves a CBPR project, we recommend that our proposed CBPR peer review recommendations be applied to such submissions. This is particularly relevant as these funding mechanisms largely support developing investigators in the pipeline. It is during this time where the NIH can begin to truly transform the clinical research enterprise by supporting new and junior CBPR investigators. We recognize that until a cohort of CBPR researchers is developed, it will be challenging to identify senior-level research mentors for K, T, and F submissions employing a CBPR approach. We recommend the inclusion of seasoned community partners as mentors for investigators submitting career development applications. Furthermore, we recommend that a specific K and T grant program be developed that would support investigators to become experts in CBPR.

6. Additional Comments:

Composition of NIH Peer Review Advisory Committee
To ensure that there is true community engagement and participation at all levels of the peer review process, there must be community representation on the NIH Peer Review Advisory committee. To date, there are no community representatives on this advisory committee, even with the recent addition of 8 new members. To balance out the committee's composition, we recommend that there be a reserved number of seats for community members on this committee.

Key Organizations and Networks
Though not exhaustive, the following is a list of key organizations and networks that NIH should reach out to as partners as it seeks to further understand and strengthen its peer review process:

Association of Asian Pacific Community Health Organizations (www.aapcho.org/site/aapcho/)
Asian and Pacific Islander American Health Forum (www.apiahf.org)
Asian Pacific Environmental Network (www.apen4ej.org)
CDC Prevention Research Centers ((http://www.cdc.gov/prc/) and its National Community Committee (http://www.hpdp.unc.edu/ncc/)
California Breast Cancer Research Program (www.cbcrp.org/)
Community-Based Public Health Caucus of the American Public Health Association (www.sph.umich.edu/cbphcaucus/)
Community-Based Research/CBPR Funders Interest Group
Community-Campus Partnerships for Health (www.ccph.info)
Community Coalition for Environmental Justice (www.ccej.org)
Community Partner Summit Mentoring and Policy Work Groups (http://depts.washington.edu/ccph/cps.html)
Detroit Urban Research Center (www.sph.umich.edu/urc/)
For A Better Bronx/South Bronx Environmental Justice Partnership

Guam Communications Network (www.guamcomnet.org)
Harlem Community and Academic Partnership (www.nyam.org/initiatives/cues-research.shtml) and (www.harlemresourceguide.org)
Hazard Perry County Community Ministries (www.hpccm.org)
Indigenous Environmental Network (http://www.ienearth.org/)
Institute for Community Research (www.incommunityresearch.org)
Kellogg Health Scholars Program (www.kellogghealthscholars.org/)
National Community-Based Organization Network
National Community Committee of the CDC Prevention Research Centers (www.cdc.gov/prc/about-prc-program/committees.htm)
National Association of Community Health Centers (www.nachc.com)
NIH Council of Public Representatives (http://copr.nih.gov/)
NIH Scientific Interest Group on CBPR (http://grants.nih.gov/grants/training/esaig/cbpr_sig.htm)
Northwest Health Foundation (www.nwhf.org)
Orange County Asian Pacific Islander Community Alliance (www.ocapica.org)
Paso del Norte Health Foundation (www.pdnhf.org/)
Policy Link (www.policylink.org)
Portland State University (www.pdx.edu)
Southeast Community Research Center (www.cbpr.org)
Southwest Network for Environmental and Economic Justice (www.sneej.org)
Southwest Organizing Project (www.swop.net)
University of Michigan-Ann Arbor School of Public Health (www.umich.edu)
University of North Carolina – Chapel Hill School of Public Health (www.unc.edu)
Urban Indian Health Institute (www.uihi.org)
West End Revitalization Association (http://www.wera-nc.org/)
Yakima Valley Farmworkers Clinic (www.yvfwc.org)

We also recommend looking beyond the United States for potential partners, such as the Wellesley Institute (www.wellesleyinstitute.com), the Ontario HIV Treatment Network (www.ohtn.on.ca/), and the Canadian Institutes of Health Research (http://www.cihr-irsc.gc.ca/e/193.html

The following people and organizations are submitting these comments (listed below). We have come together through the support of the Community Partner Summit Policy Work Group (see http://depts.washington.edu/ccph/cps.html). We are eager to work with you to further understand and improve the NIH peer review process and look forward to hearing how we can become more involved, individually and collectively. Thank you.

Ann-Gel Palermo (ann-gel.palermo@mssm.edu), Harlem Community and Academic Partnership, New York, NY
Alice Park (alicep@uihi.org), Urban Indian Health Institute, Seattle, WA
Sarena D. Seifer (sarena@u.washington.edu) and Kristine Wong, on behalf of Community-Campus Partnerships for Health, Seattle, WA

Vickie Ybarra (vickiey@yvfwc.org), Director of Planning and Evaluation, Yakima Valley Farmworkers Clinic, Yakima, WA

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