

## **Department of Health and Human Services**

### **Board of Scientific Counselors**

**May 12 – 13, 2014**

NCHS Auditorium  
3311 Toledo Road  
Hyattsville, MD 20782

### **Meeting Minutes**

The Board of Scientific Counselors was convened on May 12-13, 2014 at the National Center for Health Statistics in Hyattsville, MD. The meeting was open to the public.

## **MEETING SUMMARY** **May 12 - 13, 2014**

### **ACTION STEPS**

- The next BSC meeting will take place on October 29-30, 2014.
- A motion to accept the latest BSC review was carried. A cover letter will be circulated to the Board and officially submitted to NCHS with the review.
- A white paper/outcomes report from the February 2014 NAS Workshop about next steps for NHANES DNA collection (and associated issues) will be reviewed by BSC members in preparation of a full discussion in the October 2014 meeting.

*(Please refer to PowerPoint presentations for further specifics)*

### **Monday, May 12, 2014**

#### **Welcome, Introductions and Call to Order**

Raynard Kington, M.D., Ph.D., Chair, BSC

#### **NCHS Update**

Charlie Rothwell

The update included NCHS in the news (over 370 articles from January - April 2014) as well as BSC departures and other personnel updates. NCHS will soon advertise for deputy director and planning/policy/technology positions. Efforts are underway to improve data visualization, display and dissemination. The National Study of Long-Term Care Providers was nominated for a CDC/ASTOR Honor Award in Excellence in Surveillance and Health Monitoring. Office space

will be significantly reduced in the fall and NCHS will be housed elsewhere during building renovations.

A budget update was presented noting a loss of 20 - 25 million dollars from the ACA although current funding goes through FY14 for NHIS expansion and healthcare surveys. Nevertheless, FY15 will look much the same as FY14 as additional funds were obtained to partially make up for the ACA shortfall. The FY15 budget request was further delineated; and a chart depicting monetary sources was shown. What changes can be made to data collection to produce information faster while maintaining the health surveys? Survey collaborators are vital to fulfilling NCHS's mission. Program updates were presented to include the 2013 NHIS data release, publications and other DHIS activities; NHANES data and publications; and changes and accomplishments of the Division of Health Care Statistics and in the Division of Vital Statistics. Concerns were raised about the upcoming ICD-10 transition.

NCVHS is taking action on three letters to reaffirm its position on implementing ICD-10; recommending urgent actions for administrative simplification; and sharing recommendations from the Public Health Data Standards Hearing. OAE staff provided technical expertise for the *Healthy People 2020 Leading Health Indicators: Progress Update Report* (April 2014); and released *Health, United States with Special Feature on Prescription Drugs* (May 2014). Steps have been taken to improve data access and use. It is not clear whether a 2014 National Conference on Health Statistics will take place.

**Discussion** Political, professional and media attention will be focused on the first federal release of the post-open ACA enrollment period. Many methodological and policy challenges associated with the first release must be addressed. A plan will be developed to explain what Census and NCHS measure; why the measurements differ; and how the information will be used. There will not be much impact outcome to report by the next BSC meeting in October 2014. Challenges include how to think about the first quarter of enrollment, noting that some enrollment from this period actually occurred prior to the first quarter. Long-term issues to consider address demographics and the impact of Medicaid expansion on the marketplace. The NHIS asks whether people have health insurance but does not address enrollment numbers. Advanced messaging that provides context to the numbers could clear up confusion about what was happening during that period; as also holds true for health insurance data.

Historically, statistical agencies have presented data and explained them afterwards. In this regard, a public presentation that provides context is a new approach. Many states and local communities are considering open data and simplifying the number of on-line systems. Another issue centers on the question of, "how aggregate is aggregate enough." NCHS supports the Health Indicators Warehouse, whose metadata component identifies survey strengths and weaknesses. How will users understand data quality and accompanying caveats? As more data become available, they may need to be "perturbed" for reporting but then, unperturbed when researchers want to examine the actual data. While more availability means a greater chance of inadvertent disclosure, it would help users coalesce varying data access procedures from different federal agencies.

### **Trends in Obesity in the United States**

Cynthia Ogden, Ph.D., Epidemiologist and NHANES Analysis Branch Chief

Americans are heavier than they were in the 1960s, noting changes in BMI distribution in adults and adolescents. Main points were presented from a paper published by JAMA in February 2012 entitled, "*Prevalence of Childhood and Adult Obesity in the United States, 2011-2012*"

(Cynthia L. Ogden, Ph.D.; Margaret D. Carroll, M.S.P.H.; Brian K. Kit, M.D., M.P.H.; Katherine M. Flegal, Ph.D.). Just before the paper was published, a CDC press release noted that obesity rates for young children plummeted 43% in a decade. While the number was calculated correctly, the data was presented differently than in the above paper; and other articles came out saying the 43% results were overblown. Another JAMA paper (April 2014) entitled, *“Prevalence and Trends in Obesity and Severe Obesity among Children in the United States, 1999-2012”* showed an increase in obesity rates.

Concerns about recent trend analysis were addressed, to include oversampling of non-Hispanic Asians in 2011-2012; no adjustment for race/ethnicity; no adjustment for multiple statistical tests; start of trends in 2003-2004; and bouncing of estimates. Obesity trends were further delineated; and it was noted that the new data will help clarify the trends. Obesity is a very important public health concern with lots of visibility, many players and interests. The NHANES analysis makes important contributions in the trends and many other analyses related to obesity.

**Discussion** Some concern has been expressed in the press that the identified obesity trends had been driven by politics. Within the debate, some have questioned the data. A 2009/2010 report was referenced with regard to changes in BMI. A suggestion was made for data providers accused of cherry picking to provide alternative data for interpretation. It is important to get at what is happening more currently with obesity. A discussion ensued about how the media verses data providers interpret data. The usefulness of providing greater context about published data in advance was reiterated. More quadratic modeling was recommended when examining whole trends. Where a trend begins is especially important to note when a downward trend persists. NCHS should consider creating a role that facilitates the transition between science and policy. It is useful to think about what people will do with data and what additional information might be needed. An additional suggestion was made to focus on educating (via talking points) while maintaining a clear line between fulfilling the function of a statistical agency and educating.

### **OAE Review**

Don Steinwachs, Ph.D.

Results of the OAE review were presented. The review examined functions, organization, accomplishments, products, challenges, ongoing issues, strengths and opportunities of the organization. A wide range of recommendations were presented, including: developing a comprehensive, overall strategic vision and planning process; conducting a systematic evaluation and capturing user data and feedback; establishing priorities and aligning resources; establishing or formalizing new partnerships and cooperative ventures; supporting and enhancing staff development and deployment; defining and improving data dissemination; and determining data linkage needs and opportunities.

### **Comments**

Linette Scott, M.D., BSC Review Liaison

A coordinated and broad overall strategic direction for OAE reviews is recommended by the BSC. It is important to leverage and engage but not duplicate efforts relative to the healthcare debate.

### **OAE Response**

Irma Arispe, Ph.D., Director, Office of Analysis and Epidemiology

NCHS and OAE must distinguish their roles from other agencies such as AHRQ and HRSA. OAE has a commitment to high quality, unbiased and non-political work. Efforts are underway to better communicate between programs. OAE and CDC are collaborating on national reporting efforts. Harmonizing indicators represents a big challenge. In the past year, work has been done on a National Prevention Strategy. Longer-term, collaborative efforts with AHRQ on the National Healthcare Quality and Disparities Reports continue; and new programs (e.g., linkage, working jointly with Public Use Mortality Files and others; the Health Indicators Warehouse) are being developed. Research is strong in areas such as linkage quality; and a new health economics team is in place. The Injury Program has been reinvigorated.

Personnel shifts were mentioned. Several goals identified from a self-assessment include maintaining scientific excellence of staff; innovation; and relevance of the work as well as participation in important public health and health policy initiatives. *Health, United States 2013* will be released in May 2014. A united strategic vision is important and challenging. Good management can only be made with evaluation and data about how programs are working.

**Discussion** On a tactical level, a question was posed about bridge race population estimates (an analytic tool). The hope had been to end bridging within a few years when state certificates matched OMB standards. With Census now considering new race/ethnicity categories, it is not clear when bridging will end. A recommendation was made to push the ten or so states that are behind to convert in order to get off the temporary bridged race.

Developing a vision and a strategic plan is an ongoing process that must be implemented. This is a new process for NCHS to undertake within its operating divisions and as an agency. As the analytic piece of NCHS, OAE is a cross-cutting group that along with data divisions, examines survey content, among other things. It is clear that developing a vision and strategic plan cannot be done in isolation: planning must be in sync between data divisions and with NCHS overall. Broad priorities must be clarified.

It is important to ensure that NCHS programs communicate effectively and but consider cost and value of products and programs as well as available resources. At present, there is no well-defined process for deciding what products to cut; or how to raise more external funding. What are NCHS's comparative advantages when competing for dollars? Another concern lies with production efficiency (or how to organize a cross-cutting structure with different technical expertise and application areas). OAE's first staff retreat, which made use of its Employee Viewpoint Survey, was a great opportunity for people to get to know each other.

Visioning is valuable for setting a framework but can get bogged down at a more specific level. Successful strategic planning on the Vital Records side of NCHS was described. A grid developed with describable steps has become an ongoing and helpful tool. Broader input has been sought from NAPHSIS membership.

NCHS is uniquely positioned within the federal statistical community to produce high quality data linkage products. This niche should be worked into a strategic vision that includes creating tools that are not usually available such as linkage weights. If constituencies are built around such data products, there is less chance of funding cuts. While data linkage has huge potential, there must be a market for it. The Department should recognize the needs of users of critical health and healthcare data products; and encourage NIH and AHRQ to use those products. Building bridges to the outside community was recommended. To date, linkage to mortality data has been the priority. OAE, NHIS and Vital Statistics are working well together to improve death data quality. CMS files offer tremendous opportunities. NCHS is matching to produce the

National Death Index, which is not a statistical system. A birth counterpart would be useful for survey and longitudinal purposes in the future. Deriving high value information drives where to go after linkage.

### **Potential Small Grants Program**

Virginia S. Cain, Ph.D., Director, Extramural Research, NCHS

The history of an extramural research program was described. Several program reviews (e.g., Mortality; Natality; Ambulatory Hospital Care Statistics Branch) recommended the development of an extramural grant program. Others such as NHIS and NHANES indicated the need for mechanisms that promote products. Creating a grant program could address the need to promote products, build constituency and contribute to scientific knowledge. Another area with real potential is survey methodology, noting how helpful it is to support methodological research.

A two-year framework has been recommended, which would support three or four small grants of \$50,000/year (plus indirect costs). This would be funded from the NCHS budget as of 2015. There are advantages to potentially partnering with NIH, including an NIH review. Other potential partners include ASPE (particularly around LGBT issues) and AHRQ. Possible topics were suggested. New data from NCHS could be targeted to build awareness about what is available; and basic survey methodology could be useful. There is interest in promoting use of linked datasets.

**Discussion** Input was requested about areas to focus on as well as a small grants program review process. Consideration should be given to what is useful to NCHS rather than to individual researchers; and about whether to focus on data products or survey methodology rather than both. An inquiry was made about the SBIR tap and whether such a program could be considered non-research. If money must be spent on SBIR, a determination of whether issues are SBIR-appropriate must be taken into account. A broader view allows for greater funding opportunities. Because innovation and communication of a grant program is appropriate for SBIR mechanisms, figuring out how to tap back into that system would be worthwhile.

Once a set of grants goes through a review process, commitments can be obtained upfront or grants can later be “sold” to other centers if the program has more projects than it can fund. It is important for NCHS to invest upfront in such a program to emphasize serious intent. Methodological and programmatic issues must be examined. Additional funds from other agencies would provide more options. Other potential partners were suggested (e.g., Bureau of Transportation Statistics; disease-specific CDC Centers. Investigators should decide what problems to work on rather than the agency determining key issues are (examples of issues given). Limited funding and a relatively narrow mission does not allow for solicitation of many ideas (with the possible exception of targeted populations). Inclusion of post-docs or training grant opportunities is desirable. The difference between grants and contracts was noted. There was general agreement among BSC members to support the small grants program.

### **Continued Discussion of Future Reviews**

Virginia S. Cain, Ph.D. and Charlie Rothwell

The first round of program reviews have been completed. Previous discussion about future direction was reiterated, emphasizing support for a program overview that is more specifically defined by a special issue. It was agreed that future individual program reviews are not the best

use of the Board's time. A suggestion was made to better educate the BSC about the function of different agency divisions; the Center set-up; and how the pieces fit together. The NCHS strategic plan will help the Board understand its priorities. What are NCHS's challenges; and what should they eliminate from their roster of activities?

Mr. Rothwell would like to improve programs by examining certain issues in a focused way. For example, how should NHIS transition from a personal interview survey to a phone survey to the internet? How can information be better shared across data divisions? Should products be structured differently to showcase breadth rather than silos? What is the data plan for monitoring the ACA? What is the best way to interact with AHRQ? How can the BSC help the different groups work together, especially in the area of multiple survey divisions? Focus should be on linkages that cut across different areas as well as on communication and dissemination.

The BSC would benefit from receiving background information and specific questions about issues under discussion in advance of meetings such that the focus of meetings is more on discussion than presentation. The group could move from addressing issues to working more broadly on a strategic vision. Another suggestion was made for each active program in major offices to work on one relevant strategic planning topic that then gets presented to the BSC as part of a broad Center-wide planning discussion.

Mr. Rothwell will examine the cross-cutting potential of what the divisions have defined as issues and bring the BSC a list of four to five items to address. He will also discuss the creation of a strategic plan with his staff.

In the next three to four months, the BSC can help NCHS prepare for the upcoming ACA data products. Another suggestion was to use the ACA as a case study rather than as part of a core mission to provide data. The broader challenge is how to shape a usable and practical plan about NCHS's core mission that does not demand many layers of clearance. The statistical agency's role should be clearly defined, noting that its core role should not change with administrative shifts. Its work must be policy-relevant with better coordination between surveys. Because NCHS exists within CDC, how the agency helps with CDC's mission must also be clarified. Defining outcomes is a part of the process.

BSC members were asked to review some confidential financial disclosure report forms (various categories on the forms were delineated). Discussion ensued about the usefulness of having a group of "outsiders" help to make something happen. The BSC offers a different perspective about how change might occur, taking federal and state perspectives into account. Tracking progress helps with the planning process.

The meeting was adjourned at 4:50 p.m.

## **Tuesday, May 13, 2014**

### **Welcome and Call to Order**

Raynard Kington, M.D., Ph.D., Chair, BSC

### **National Study of Long-Term Care Providers: Update Since 2009 BSC Review**

Lauren Harris-Kojetin, Ph.D., Chief, Long-Term Care Statistics Branch, DHCS

Dr. Harris-Kojetin described the National Study of Long-Term Care Providers (NSLTCP) before the BSC review; identified review recommendations and main actions taken since the review (noting how NCHS has used the recommendations); and discussed next steps, new challenges and opportunities. The NCHS Long-Term Care Statistics Program was described to include the mission of National Health Care Surveys and the identification of long-term care service providers surveyed. The BSC review of 2008 recommended developing a strategic plan and integrating LTC provider surveys into a unified set of surveys (accompanied by more specific recommendations). Progress in addressing these recommendations was delineated.

To address the recommendation to integrate surveys into a unified set, the NCHS is pursuing a new strategy known as the National Study of Long-Term Care Providers. The first wave of data collection was completed in February 2013. Leading to a report entitled, *“Long-Term Care Services in the United States: 2013 Overview”* (December 2013). Products of 2014 include state web tables to complement the overview report; adult day-specific and residential care-specific briefs and corresponding state estimates; and weighted frequencies for survey data. NSLTCP’s long-term vision was further described as were specific opportunities and challenges.

***Discussion*** Home care agencies represent a sector of paid providers that is not part of the study. Private pay agencies and Medicaid agencies that do not meet the requirements are not being captured. Focus rests on services for older adults and younger adults with physical disabilities rather than on residential care providers working exclusively with intellectually or developmentally disabled or severely mentally ill persons. A suggestion was made to expand the ‘providing aide’ category.

Long-term care in the ACA, largely Medicaid-funded, provides home and community-based services by home care agencies and other entities. Next steps might include the integration of what is being done in the long-term care arena with socio-demographic information about patients and costs. It can be difficult to determine what is happening in other sectors and where certain data exist in other agencies. A question was posed about the status of information on the demand rather than supply side, which could pick up informal sector and other hard-to-measure activities. Does the NHIS ask if subjects are receiving health or personal services help?

NSLTCP initially focused on providers and service users but with the work further along, it now makes sense to further examine informal care. The vast majority of long-term care is provided by unpaid friends and family but to date, the agency’s mission has been to focus on paid providers. It was noted that the CMS move towards quality measurement with caregiver/family member/patient surveys around the hospice cap has been field tested and is moving toward implementation. Learning more about how the nursing home cap is being used could enhance long-term care work in the quality arena. Creative care solutions are evolving, some outside of the “official economy.” Paid care is often a combination of efforts and funding sources not registered in the economy because it is paid for in cash or under the table.

A question was posed about how to balance the growing length of surveys against special interests of those who fund them. NCHS funds the core of the work every two years. While partners are desirable, care must be taken when adding survey content. Consideration is being given to rotating items and content. Another option is to do stand-alone surveys (e.g., nursing home, home and hospice surveys). It was suggested that the Transform Medicaid Statistical Information System (MSIS/T-MSIS) is worth examining as an administrative data source.

In response to a question about how the BSC can be useful to the LTCSP, a request was made for the group to continue raising pertinent issues and helping to work through challenges and opportunities. It is useful for the BSC to examine programs that are ready for change.

### **Using Mortality Data for Public Health Surveillance**

Paul D. Sutton, Ph.D., Health Scientist, Mortality Statistics Branch Division of Vital Statistics

Current mortality surveillance projects and several in the works were described as were the data, the infrastructure being built and some analysis of the reliability and usefulness of the work. Current projects include a validation of rare vaccine preventable disease deaths; and pneumonia and influenza mortality surveillance. The classic surveillance system (122 Cities System) was described. A parallel surveillance system for the past flu season has been developed that may replace the 122 Cities System within the next few years. The vital statistics-based system improves upon the 122 Cities System in several ways: it provides more specific information (e.g., exact death date); it is automated; it has a consistent process for identifying records and an ability to drill down to lower levels of geography or to focus on specific areas; it can report out daily rather than weekly; and it can identify trend changes one to two weeks earlier than the 122 Cities System. A reporting lag evaluation has begun.

Developing partnerships were identified with the hope that more are forthcoming. Challenges and opportunities for national mortality surveillance were presented (e.g., improved timeliness; data quality; building a national mortality surveillance IT infrastructure) as were objectives and proposed indicators of the new Mortality Surveillance Indicators Project.

**Discussion** The process of gathering provisional statistics in Illinois was described as an example of the potential that surveillance has at the state level. As a statistical agency, surveillance enables NCHS to help CDC just as it ensures that CDC provides quality data. The idea is to work on the data provisionally, improve it and make it available under certain conditions. As a result, final files are made public more quickly (although at the state level, it was noted that when final files come out more quickly, the window for provisional statistics is shortened). In addition, data quality and the identification of issues are improved by examining records in aggregate even before a file is finalized.

Proposed indicators of the Mortality Surveillance Indicators Project were further discussed. Would it be useful to track healthcare amendable causes of death? Are drug overdoses and drug poisoning deaths the same? What is the connection between public health and law enforcement relative to drug overdoses? Is there an ability to examine health services or deaths related to medical errors? The project aims for a core set of indicators that are of value, noting that all suggested indicators will be considered.

A suggestion was made to develop a chart for the indicators that show different reporting periods and geographical representation of data. The indicators, which will be stand-alone, will provide a means of tracking first at the national level and perhaps later, at smaller geographic levels. A periodic snapshot of annual data will be produced.

### **CDC Priorities, Office of Public Health Scientific Services and the Surveillance Strategy**

Chesley Richards, M.D., M.P.H., Deputy Director for Public Health Scientific Services, CDC



The world of health information is transitioning in significant ways (e.g., to rapid, automated whole genome characterization; real time, integrated electronic data; population health management; informed consumers; and distributed big data analytics). There will be increased informatics interoperability across jurisdictions and data systems with electronic data; more partnerships and collaborations; and a revolution of analytics, visualization and communication on public health data and information. Opportunities in emerging data trends for public health were identified, noting that timely, high quality and actionable data fulfills the ten essential functions of public health (as illustrated in a chart).

CDC's priorities are to improve health security at home; to better prevent the leading causes of illness, injury, disability and death; and to strengthen public health and healthcare collaboration. It was noted that the number of CDC embedded field staff has been steadily growing; and funding to state and local governments is increasing. Sixteen hundred CDC staff work globally in sixty countries.

The reorganization resulting in the creation of the Office of Public Health Scientific Services (OPHSS) was described. Its focus is to put data and information into the hands of public health decision makers at the right time in the right place. The intention is to create a more efficient system by reducing silos and redundancies. The CDC Director will provide a report by July 2014 outlining opportunities for consolidating data collection systems. Success of the surveillance strategy outlined will improve: leader engagement at CDC; national policy effectiveness; adoption of informatics and technology; strategic relationships with vendors; and cross-cutting platforms or data streams.

**Discussion** While the surveillance strategy is domestically-focused, the effort will be connected in a meaningful way to a global perspective. There is much to contribute to and also learn from developing countries about surveillance. A partnership between CDC, DOD and other departments has produced a Global Health Security Initiative.

It is not clear why BRFSS was taken out in the reorganization relative to state-based estimates. The data collection efforts of NHIS, BRFSS, NHDS and HCUP each have value and speak to somewhat different audiences. Should NHIS be expanded to have more granularity in terms of states or should something different be done with BRFSS? These issues must be tackled in the near future. Isn't there a more efficient way to sample people with disease-focused surveys?

A suggestion was well-received to work with CMS and Medicaid around the Medical Information Technology Architecture (MITA), a business process for population health and managing registries that is high-level but not well-defined.

Further discussion about the surveillance strategy ensued. Initiatives are mostly internal as mandated by Congress. There is a problem of intent with the BRFSS surveys. States want their own data collection system even with its accompanying problems. If that is taken away, what is an adequate replacement? NHIS, even if made bigger or completed more quickly, might not meet that requirement unless it allows states to ask additional questions.

Budgets are being reduced as requirements and data needs grow. How can existing resources best be used? Transparency, leadership, highlighting decreases in functionality and making recommendations are part of the plan moving forward. Quality measures were discussed relative to the integration of public health, primary care and health care. Surveillance strategy must address the challenges and tensions between the purpose and use of registries.

**NHANES and National Academy of Sciences Meeting on DNA:  
Bank Program Preliminary Report**

Susan Lukacs, D.O., M.S.P.H., Science Advisor, Office of the Director, DHANES;  
Captain, U.S. Public Health Service

An overview of the preliminary report of the NHANES DNA Bank Program was presented that noted changing consents for use of biological specimens including DNA in a national repository over time. The DNA Bank was closed to new proposals in 2012 and will remain closed until a new policy on reporting results is developed. Technologies are evolving faster than an ability to manage research results; and there is now more concern about obtaining incidental findings in genome-wide association studies (GWAS). Binning the genome (three bins) was described. The BSC suggested broader discussion occur as this is also an issue for other population-based studies.

NCHS commissioned the National Academies Committee on National Statistics to convene a February 2014 workshop to determine if and how NHANES and other population surveys with banked DNA specimens should return results from genetic studies. A white paper is being written on workshop outcomes. NHANES next steps were described (specifics provided).

**Discussion** A disconnect between some ethicists and lawyers with advocate and clinical geneticists was noted relative to disclosure. Many in the workshop were not familiar with the constraints of statistical agency confidentiality. NCHS has good guidelines about what is and is not reportable for conditions like cholesterol but it was noted that NCHS needs permanent advice about guidelines as the field is changing so dramatically.

The BSC will wait for the full NAS report with regard to retrospective specimens. While there may have been consensus that NCHS would not have to provide information back to participants relative to past agreements, there was no such agreement about the future. The notion of consensus was questioned by another workshop participant. The outcomes report will help BSC members determine whether there is agreement about opening up the NHANES DNA data bank although it was noted that the report reflects what transpired rather than offering recommendations. Future plans for collecting DNA will be discussed at the next BSC meeting in October 2014.

**PUBLIC COMMENT** None.

The meeting was adjourned at 12:30 p.m.

To the best of my knowledge, the foregoing summary of minutes is accurate and complete.

/s/  
Raynard S. Kington, M.D., Ph.D.  
BSC Chair

11/14/2014

DATE

## **Attendees**

### **Committee Members**

#### **Present**

Raynard S. Kington, M.D., Ph.D., Chair BSC  
Wendy Baldwin, Ph.D.  
Virginia S. Cain, Ph.D., Executive Secretary  
Michael Davern, Ph.D.  
Mark Flotow, M.A.  
Hermann Habermann, Ph.D.  
Christine L. Himes, Ph.D.  
Genevieve M. Kenney, Ph.D.  
Stanley Presser, Ph.D.  
Margo Schwab, Ph.D.  
Linette T. Scott, M.D., M.P.H.  
Alan M. Zaslavsky, Ph.D.  
Katherine K. Wallman, Ex-Officio, OMB (via phone)

#### **Invited Guest (By Phone)**

F. Javier Nieto, M.D., M.P.H., Ph.D.

#### **Absent**

Ana V. Diez Roux, M.D., M.P.H., Ph.D.  
Carol J. Hogue, Ph.D., M.P.H.  
Thomas A. LaVeist, Ph.D.  
F. Javier Nieto, M.D., M.P.H., Ph.D.  
David Takeuchi, Ph.D.

### **Staff and Liaisons**

Irma Arispe, Ph.D., OAE, NCHS Staff  
Clarice Brown, M.S., Director, DHCS, NCHS Staff  
Charles Rothwell, NCHS  
Nathaniel Schenker, ORM, NCHS Staff  
Tammy Stewart-Prather, OIS  
Lara Akinbami, OAE  
Negasi Beyene, ORM/RDC  
Amy Branum, DVS  
Verita Buie, NCHS/OPBL  
Anjari Chandra, DVS/RSB  
Jim Craver, OAE  
Renee Gindi, DHIS  
Rebecca Hines, OAE  
Tammara Jean Paul, OPHDSS  
Brady E. Hamilton, NCHS/DVS  
Denys Lau, DHCS  
Jennifer Parker, OAE  
Tommy Seibert, OIS/IDPS

Iris Shimizu, NCHS/ORM  
Sandy Smith, NCHS/OCD  
Betzaida Tejada, DVS  
Anjel Vahratian, Ph.D., DHIS  
Stephanie Ventura, DVS  
Kassi Webster, OPBL

**Others**

May 12, 2014

Gladys Lewellen, CDC  
Don Steinwachs, Ph.D.  
Sirim Themsiri, OAF

May 13, 2014

Nick Holt, Social & Scientific Systems  
Jim Nowicki-Northrop Grumman  
Anne Imrie, Social & Scientific Systems  
Julia Milton, COSSA  
LaTeana Howie, OAO