

Department of Health and Human Services
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

Board of Scientific Counselors

April 22, 2010

NCHS Auditorium
3311 Toledo Road
Hyattsville, MD 20782

Meeting Minutes

Attendees are listed in Attachment 1

The National Center for Health Statistics Board of Scientific Counselors convened on April 22, 2010 at the National Center for Health Statistics in Hyattsville, MD. The meeting was open to the public.

ACTIONS

No formal action steps were identified.

- Next meeting date: September 23-24, 2010
- During discussion, a request was made for a summary of work to date on the correlation between obesity measures (such as percentage of body fat) to child onset of Type 2 diabetes, pre-diabetes or hypertension, etc. for the next meeting.
- During discussion, suggestions were also made to further discuss remote access issues; federal-state partnerships; and health reform evaluation.

Welcome and Call to Order

Edward Sondik, Ph.D., Director, NCHS and Virginia S. Cain, Ph.D., Acting BSC Chair

NCHS Update

Edward Sondik, Ph.D.

Organizational Changes at CDC: Dr. Sondik specified organizational changes at CDC since Thomas R. Frieden, M.D., MPH, became its new director in June 2009. CDC's five new priority areas were identified along an additional six "winnable battles." NCHS's particular challenge is to continue its stated mission of monitoring health and healthcare while supporting these priority areas. The focus will be on healthcare, healthcare quality and changes in morbidity and mortality. Rather than "take over," surveillance and epidemiology will help move CDC forward. Dr. Frieden believes that a recognizable and highly promoted set of key measures is critical; and that quarterly insurance figures from HIS are at the core of CDC's efforts to make a difference.

CDC's new organizational chart and accompanying changes were described (see PowerPoint presentation for specifics). Current emphasis is on support across CDC and on public health in general. At present, 35 data briefs about current public health topics inform the field and public as do *NCHS Health E-Stat* on the website; early estimates (such as the 2009 report on wireless substitution); and *Health, United States* (as well as *Health, United States In Brief*). Other program highlights include: *Healthy People*, which is evolving as *HP 2010* morphs into *HP 2020*; *The Community Health Data Initiative* in the HHS Open Government Plan; and this Initiative's *Health Indicator Warehouse*. Various symposiums (NHANES; NCHS), the opening of the NCHS Atlanta Research Data Center; involvement in the First Lady's *Let's Move* Initiative; and an NCHS budget increase were also mentioned. (Programs, symposiums, data centers and other specifics are described in Detailed Summary)

Changes on Growth Chart and Obesity/Overweight Labeling **Cynthia L. Ogden, Ph.D., Analysis Branch, DHANES**

Data about childhood obesity from the 2007-08 NHANES survey was shared. The terms "obesity" and "overweight" in children (and their various indices) were defined. Recommended cut points of body mass index (BMI) and labels of the 1990s were described as were new recommendations developed in 2007 by a committee organized by the AMA. Although cut points are not diagnostic criteria, HHS adopted these new labels in 2010, reflecting the Surgeon's General's vision for a "healthy and fit" nation. A forthcoming document will describe changes in terminology and their use at NCHS and CDC. A session on childhood obesity is scheduled for NCHS's August 2010 conference.

Differences between CDC and other reference population growth charts (WHO; IOTF; other countries) were noted. Obesity is just one connection to growth charts, some of which also monitor growth in clinical settings. Specific data sources that now include pediatric data from birth - 36 months were enumerated. Concerns were raised about the lack of data from birth – two months and pediatric nutrition surveillance data within CDC growth charts. A research project to "re-smooth those infant curves" and remove unnecessary pediatric data was briefly described. A discussion about the 2006 WHO growth chart, based on the Multicenter Growth Reference Study (MGRS) followed. A question arose about whether growth charts should be used as a general reference or as a standard. Study design, site selection and eligibility criteria were delineated. Data exclusions, primarily due to a concern about excess weight, were specified. (See PowerPoint presentation and Detailed Summary for specifics)

Discussion The controversy over changing labels was addressed, noting that complexities of the reference population must be considered. Some children do not fit the definition within growth charts (making the chart an imperfect "statistical definition" that works better for populations than for individuals), although there is less misclassification above the 95th percentile. While definitions may be imprecise, it is clear that the weight of today's population has dramatically increased over a short period of time as have hypertension, diabetes, sleep disordered breathing and other health problems. Some pluses and minuses of labeling were delineated. Educational materials about overweight children and childhood obesity are needed to train pediatricians, parents, teachers and others. A question was posed about whether current measures are understandable to policymakers.

Specifics including selection criteria, study sites and data pooling within the MGRS Study were discussed. A shift in the two sets of curves (longitudinal and cross-sectional) was primarily noticed in the birth – 24 month age range. It was suggested that a skewed distribution contributes to an arbitrary cut-off, which in turn raises statistical and policy questions. What cut-

points should be used on this population to define abnormal growth? Research has shown that before puberty, particular differences in growth are primarily due to socioeconomic rather than genetic factors. The MGRS research combines these data from different countries. Differences, similarities and exclusions in the CDC and WHO charts were reiterated. Parity was raised as a consideration within the Study. One participant made a recommendation to either follow CDC rather than WHO guidelines or go with the CDC from birth - two years, with guidance. Additional questions were raised (e.g., if the mother is not breastfeeding, how would the WHO chart be interpreted?), noting that WHO charts are not only based on feeding criteria. It is not clear how much other criteria (including high SES) affect growth patterns.

NCHS might consider the costs and implications of expanding the use of some measures already utilized for adults to children under two years of age. A recommendation was made to review the correlation between measures (such as percentage of body fat) to child onset of Type 2 diabetes, pre-diabetes or hypertension, etc. Much work has already been published in this area. The United States has shown little interest in using the WHO charts above age two, although "obesity is really above age two." Using the WHO charts under age two is complicated by other issues. A broad recommendation was made to examine the multiple sides of these issues, taking into account a relevant and upcoming Morbidity and Mortality Weekly Report (MMWR) on the topic.

Healthy People 2020: A Vision of Health for 2020

Richard J. Klein, MPH, OAE

A history of the *Healthy People (HP) Initiative* was summarized. The projected launch of program objectives is December 2010. Current goals were identified and the program structure described (see PowerPoint chart). The HHS Secretary's Advisory Council (FACA) produced a Phase I report and recommendations, which can be seen on the *HP* website. The Federal Interagency Workgroup (FIW), which involves 28 diverse federal agencies including NCHS, oversees program objectives. The role of NCHS was delineated.

Accomplishments of *HP 2010* (by area) were enumerated. Underdeveloped issues, population templates for race and ethnicity; gender; education level; family income; standard categories previously deemed optional; and newly identified optional categories were identified. The *HP Initiative's* examination of disparities for 2010 and 2020 was described, to include definitions, goals, targets and measurements (note Tables in PowerPoint presentation). It was noted that the current definition of disparity, linked to social or economic disadvantage, is hard to measure and as such, these measurements are yet to be determined. Further, the FIW and the FACA have asked for more realistic, systematic and transparent targets than those of 2010. Several methods of determining more realistic targets were outlined. A foundation section, new to *HP 2020*, was described. For *HP 2020*, data will come from the new Health Indicators Warehouse. In addition to the Warehouse, the program hopes to have a state-of-the-art GIS-based data system at the country level by the end of 2010. There will be direct links to evidence-based interventions as part of the data system. Integration of health determinants across disciplines is a highlight of the *HP 2020* data system. An annual review of objectives (with public comment) will be done for the first time in the *HP 2020* program. A HP Users Prevention Conference will take place in the spring of 2012.

(See PowerPoint presentation and Detailed Summary for specifics)

Discussion Various methodologies and health indicators used by *HP* will be available to state and local health departments to help them set targets that are consistent with national

goals. IOM is contracted to examine and recommend *HP 2020* updates. *HP* will coordinate with other indicator activities (such as the *SOUSA State of the USA*), when possible.

It was noted that the 10 percent improvement default is not applicable in all situations. When this occurs, alternative methods will be used and justified. It was suggested that a list be devised of the top ten “killers” or most expensive issues to tackle. Snapshots or benchmarks are helpful within the “encyclopedia” of *HP* indicators. More discussion followed about summary measures, used to give a global picture of health. *HP 2020* will expand efforts to summarize thousands of health measures for interpretation purposes.

Report of National Survey of Family Growth (NSFG) Program Review **Wendy Manning, Ph.D., Chair, NSFG Review**

Called America’s “fertility survey,” the NSFG measures various health indicators. A history of the group was presented along with a brief description of panel members and the review process. A draft report of findings has been circulated and revised. In 2006, the survey moved to continuous interviewing. Since 2002, men have been interviewed; measures refined for contraceptive use, fertility, fertility intentions and event histories; and topics expanded to include new health concerns. A different NICHD-funded project (“Integrating U.S. Fertility Surveys”) provides weights and measures allowing for analysis over five decades.

NSFG’s is part of the Reproductive Statistics Branch of NCHS. It was noted that new data will be released by a contracted group at the University of Michigan in the summer of 2010 that addresses accomplishments, strengths, challenges and recommendations of NSFG, a summary of which was presented to participants.

(See PowerPoint presentation and Detailed Summary for specifics)

Discussion NSFG data and national longitudinal surveys are used to follow child trends of various institutions. It was reiterated that the NSFG survey is underappreciated as demonstrated by inadequate staffing and funding levels. While the data are used for policy purposes, policymakers do not always understand the data source. The NSFG panel has expressed interest in a larger sample with more information about certain geographic areas. Questions remain about biomarkers (although not every survey needs them); the format of longitudinal data; and age range, especially relative to men’s and multiple partner fertility. Dr. Manning would like to see some investigator-initiated longitudinal follow-up studies.

Program Response

William D. Mosher, Ph.D., NSFG Team Leader, Reproductive Statistics Branch, DVS

Three urgent sets of tasks were enumerated: 1) prepare public use files and code books for the 2009 and 2010 NSFG data; 2) award a new contract for the next survey; and 3) begin the survey with a new contractor. A history of previous planning meetings, questionnaire overhauls and support for increasing sample size and age range were outlined. It was thought to be time for another strategic planning process to consider: 1) involvement of survey funders; 2) planning consistent with the overall mission; and 3) the development of a planning group that reflects the new composition of NSFG users (including from the fields of economics and public health). Annual NSFG research conferences in 2011, 2012 and 2013 are desirable. Further discussion about other options and goals raised by Dr. Manning was recommended, especially if costs can be controlled and response rates kept high. A review of core content and modules should be further considered although risks depend upon the complexity of the modules. CDC has noted that a survey without dramatic content changes is more useful to policy development and

programs. While it is not likely that NSFG will ever generate estimates for all fifty states, it is possible to change sample designs to produce data for specific regions.

Some marketing efforts are already underway (e.g., improved website, presentations; targeted publications; research conferences; giveaways; briefings on the Hill) but further expertise is needed to institute webinars and other electronic ways to reach new audiences. It would be useful to learn about what other surveys do to improve user experience. Faster data dissemination will be facilitated by 1) work completed for the 2009 and 2010 data; 2) increased staff; and 3) software advances. (See Detailed Summary for specifics)

Discussion It was suggested that minimal interaction occurs between programs. Questions were posed about the effectiveness and expense of Facebook for these purposes. Research conferences and an advisory panel present potentially fruitful opportunities for more interaction.

What is happening in other countries was briefly discussed, noting other healthcare research and ASPE's work to standardize measurements across countries (within the OECD). The first report using the new data includes some international comparisons on contraception. A question was posed about the offspring of the studies relative to child health issues. Collaboration or information exchange with the National Children's Study (examining families before pregnancy and fertility issues) was suggested.

Liaison Response

Llewellyn Cornelius, Ph.D., Kathleen Mullen Harris, Ph.D., BSC Review Liaisons

Major challenges include: timeliness of data release and an attempt to get them out earlier; expanding the user base, which involves promoting research opportunities; showing how the data can be studied in public health; and making the data more accessible. Staff expansion and continuous interviewing will improve timeliness. Taking advantage of changing technology (e.g. automated codebook and documentation) will involve additional costs but will speed up the process.

Discussion Communicating about such concerns as data release delays is important. A balancing act exists between timeliness of release and resources provided to users. The Research Data Center (RDC) was raised as a broader issue for NCHS. Ways to access contextual data were discussed (shortcomings of Stata's capacity were noted). Providing tools that people use should be a priority.

HHS Community Health Data Initiative

Linda Bilheimer, Ph.D., Director, OAE

Secretary Sebelius' vision for HHS is to release useful and accessible information to the public. IT entrepreneur and DHHS Chief Technology Officer Todd Park oversees this initiative of the HHS Open Government Plan. Agency Open Government Plans, released in April 2010, can be viewed at open.gov. The goals of HHS's Community Health Data Initiative were described (see conceptual framework for CHDI chart in PowerPoint presentation). The Health Indicator Warehouse being developed by NCHS will function as the user dataset. Other data warehouses (such as a Public Health Infrastructure Warehouse) will be developed over time. Ideas and commitments that emerged from a brainstorming meeting of organized by IOM (March 11, 2010) were described. Next steps were summarized. (See PowerPoint presentation and Detailed Summary for specifics)

Discussion A major focus of the Open Government Initiative is to get information to people who don't understand that the data exist. There must be clarity about where data driving public policy comes from. The use of different approaches to engage more people (e.g., blogs) were discussed. NOAA's methods of distributing weather-related information represent an analogy and model for CHDI's goals. Questions covered such topics as ownership of public data applications and how to protect confidentiality. HHS's Open Government Plan hopes to improve the RDCs while preserving confidentiality although it was noted that with public use datasets, preserving confidentiality is a growing challenge. Another issue raised was how to quantify risk in relation to the datasets. "Bad data" use, much of which will shake out over time, can be expected when a significant amount of data becomes available to the public.

NCHS Health Indicator Warehouse

Amy Bernstein, Sc.D., Chief, Analytic Studies Branch, Office of Analysis and Epidemiology (OAE)

Dr. Bernstein presented a history of the Health Indicator Warehouse and a description of what needs it meets (see transcript for specifics). Components of functionality were delineated. A system design document was scheduled for completion in May 2010, along with a commitment to have it functional by December 2010. The initial v1.0 program will be fairly basic, to be improved upon at a later time. Next steps were presented. (See Detailed Summary for specifics)

Discussion The v1.0 will have data from the *Healthy People* program; *Community Health Status Indicators*; *SOUSA* and *County Health Bank* data and other federal programs. A discussion followed about how to indicate data quality of varied sources. Future plans to improve, standardize and maintain quality control of data were articulated although it was noted that the first v1.0 report (December 2010) will use previously disseminated data without much explanation or standardization. The Health Indicator Warehouse is developing collaborative relationships.

Data Strategy to Monitor Health Reform: Role of the BSC

Lynn Blewitt, Ph.D.

How will the impact of health reform be measured? Dr. Bilheimer is sure that applications will be developed to monitor health reform. She noted that some interventions garnering the most interest will not be useful for short-term tracking, as the County Health Rankings discovered. Counties must determine how to track change over time. Sample sizes need further consideration in order to track change more often at the state level and to monitor key measures (such as disparities) annually. It is easier to get state representative samples from big states.

Discussion Now is the time to establish a system to collect representative state samples. There are implementation challenges to consider as well as trade-offs and value judgments about how to interpret those trade-offs. In addition to coverage issues, questions remain about whether access is actually improved. It is not clear whether federal indicator data systems exist to monitor health reform. All of the above depend on what is meant by health reform. The intention of an upcoming NAS workshop funded by ASPE and Census is to determine what survey should monitor access expansions (CPS; ACS; IHIS; maybe MEPS), using state representation as criteria.

A new survey would take welfare reform research into consideration and a NHIS panel would be a valuable addition to the process. Data policy should accompany health reform policy.

Funding is only available for cost effectiveness research. In coming years, the Department will face implementation challenges (state-based) and health care reform questions. A cooperative effort with MEPS is recommended. Academy recommendations include state-level data with "state represented" as criteria. Default access measurement is the ACS, due to its huge sample sizes. A significant policy issue within DHHS centers on healthcare reform evaluation, monitoring and accessing sufficient information to make ongoing adjustments. It is important to track population health in a way that informs decisions over time.

One participant stated that states should contribute financially to the federal government's efforts to provide state-level estimates. State-federal partnerships that already exist were named. The role and relationship of the Behavioral Risk Factor Surveillance System (BRFSS) to the Health Reform survey was discussed. A suggestion was made to examine the Transportation Department's federal-state partnerships; challenges encountered by the National Crime Victimization Survey; and the NCES Survey. Another suggestion was to group small states with similar problems together rather than address each state individually.

Plan Next Steps

The next meeting of the Board of Scientific Counselors will take place on September 23-24, 2010.

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

- s -

7/15/2010

Acting Chair Virginia S. Cain, Ph.D.

DATE

Attachment 1

Attendance

Committee Members

Lynn Blewett, Ph.D.,
Llewellyn Cornelius
Kathleen Harris
Holly Hedegaard, M.D.
Graham Kalton, Ph.D.
James M. Lepkowski, Ph.D.
Michael J. O'Grady, Ph.D.
Ruth E.K. Stein, M.D.
Katherine K. Wallman, Ex Officio Member (by phone)

Absent

Ronald J. Angel, Ph.D.
Kenneth Prewitt, Ph.D.
José Escarce, M.D., Ph.D.

Staff and Liaisons

Virginia S. Cain, Ph.D., Executive Secretary
Llewellyn Cornelius, Ph.D., BSC member
Kathleen Mullen Harris, Ph.D., BSC member
William J. Scanlon, Ph.D. – NCVHS Liaison
Edward Sondik, Ph.D., Director, NCHS

Others

Joyce Abma, DVS
T. Monique Bailey, NCHS
Linda Bilheimer, OAE, NCHS
Amy Bernstein, OAE, NCHS
Kevin Beverly, SSS
Dara Blachman, OAE, NCHS
Stephen Blumberg, NCHS
Clarice Brown, NCHS
Verita Buie, OPBL, NCHS
Anjani Chandra, DVS
Traci Cook, OPBL, NCHS
Jim Craver, OAE
Latria Dolberry, OIT, U. of MD
Mark Eberhardt, DHANES, NCHS
April Falconi, Academy Health
Jane Sisk, NCHS
Veena Goud, DVS
Marjorie Greenberg, NCHS
Leda Gurley, OAE
David Huang, OAE
Vince Iannacchione, RTI
Susan Jack, DHIS, NCHS

Cliff Johnson, NCHS
Jo Jones, DVS
Meena Khare, NCHS
Rosalind Kind, NIH
Richard Klein, OAE, NCHS
Lisa Lee, OSELS
Diane Makuc, NCHS
Gladys Martinez, DVS
Heather McAdoo, OPBL, NCHS
Pauline Mendola, OAE
Mary Moien, OPBL, NCHS
Kathy Moss, OPBL
Cynthia Ogden, NCHS
Bill O'Hare, Casey Fdn.
Sherri Rice, CDC
Margo Schwab, OMB
Catherine Simile NCHS
Sandy Smith, NCHS
Stephanie Ventura, NCHS
Julie Weeks, OAE
Rong Wei, NCHS

Presenters

Amy Bernstein, Sc.D., OAE
Linda Bilheimer, Ph.D., OAE
Richard J. Klein, MPH, OAE
Wendy Manning, Ph.D., NSFG Review
William D. Mosher, Ph.D., DVS
Cynthia L. Ogden, Ph.D., DHANES