

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

### **Board of Scientific Counselors**

**January 27- 28, 2014**

NCHS Auditorium  
3311 Toledo Road  
Hyattsville, MD 20782

### **Meeting Minutes**

The Board of Scientific Counselors was convened on January 27-28, 2014 at the National Center for Health Statistics in Hyattsville, MD. The meeting was open to the public.

## **MEETING SUMMARY** **January 27-28, 2014**

### **ACTION STEPS**

- The next BSC meeting will take place on May 12-13, 2014.
- BSC members are asked to submit candidate names for the deputy director position of the Division of Vital Statistics (based in Hyattsville, MD).
- Links to NHANES National Youth Fitness Survey data briefs will be sent to BSC members.
- Follow-up calls will take place to review NHIS content changes with NHIS staff. Developing a framework for making tough decisions about survey content is the next step.
- Next steps for BSC reviews include examining BSC comments about how to proceed; and scheduling a conference call with volunteer review committee members.

### **Monday, January 27, 2014**

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

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

#### **NCHS Update**

Jennifer Madans, Ph.D.

NCHS personnel changes were identified. To wit: NCHS's new director, Charles Rothwell, will attend the May 2014 BSC meeting. Delton Atkinson was named the new DVS director. Marjorie

Greenberg retired after 39 years of federal service, primarily at NCHS. Donna Pickett is currently the acting chief of the Classification and Public Health Data Standards staff. Tammy Stewart-Prather was named acting director of OIS. Sandy Decker from OAE was acknowledged for receiving the CDC 2013 BILA award for outstanding health economics research (“Health Service Use Among the Previously Uninsured: Is Subsidized Health Care Enough?” *Health Economics*, 2013).

The budget update revealed a very small NCHS increase, from \$138.7 million to \$140 for 2014. Some budget funds will now come from the regular budget authority rather than from evaluation funds. No funds will be forthcoming from the Prevention and Public Health Fund (in contrast to \$22 million in 2013), which will inhibit NHIS and NAMCS sample expansion and funds for Vital Statistics. The 2014 budget is less than the President requested and less than the 2013 budget which included the \$22 million in Prevention and Public Health Funds.

Program accomplishments and priorities were reviewed for the Division of Health and Nutrition Examination Surveys; the Division of Health Care Statistics; the Division of Health Interview Statistics; the Division of Vital Statistics; the Office of Research and Methodology; the Office of Analysis and Epidemiology; the International Statistics Program; and the Office of Information Services. An update of Classification in Standards activities was presented, noting a focus on the transition from ICD-9-CM to ICD-10-CM. Debbie Jackson has been named the Acting Executive Secretary of National Committee on Vital and Health Statistics and nominations are sought for two vacancies. The 2013 NCHS customer surveys were described as were outreach efforts (including website visits, publications and conferences) and media coverage.

**Discussion** In response to a question about the timetable of IRIS replacing SuperMICAR as the medical coding system, an evaluation is in process. The hope is that the new system will be functional by 2015. Other topics briefly discussed were jurisdictional conversions to the 2003 revised birth and death certificates; the lack of survey support regarding obesity as the leading medical cause of military service rejections; and relative to the International Statistics Program, the IOM report about the U.S. health disadvantage. Discussions about the report have been held with NIH, indicating the need for greater consistency on measures and further evaluation of comparability data. Discussion about the difficulties of obtaining consistent data within collaborations was reiterated.

The first Native Hawaiian and Pacific Islander National Health Interview Survey will be in the field by February 2014. If the process works and response rates are good, the survey could be used for other subpopulations identified by the ACS. Discussion ensued about the NHIS Online Analytic Real-Time System (OARS), which will allow access to confidential data as well as public use data. Originally designed to easily access state estimates, its function has expanded to include confidential data.

### **Monitoring the ACA with National Health Interview Survey Data**

Anjel Vahratian, Ph.D., Chief, Data Analysis and Quality Assurance Branch, DHIS

The presentation focused on Affordable Care Act (ACA)-related items. The 2014 DHIS Analytic Plan was presented. It included a description of the NHIS Early Release Program and NCHS publications (such as the Health Insurance Coverage Report, issued quarterly; data briefs; National Health Statistics reports; a series of summary health statistics reports on children, adults and the population; and the Key Health Indicators Report). The 2014 DHIS Analytic Plan planned reports cover health insurance coverage; affordability; access and utilization; and preventative services. In addition, 2014 NHIS data will monitor quarterly health insurance and

key health indicators as well as produce periodic reports on financial burden and medical care. Sample size for enrollment in the Health Insurance Marketplace will increase over time.

BSC input was requested about whether topics should be monitored more frequently than annually, using Early Release data (e.g., problems paying medical bills; medication adherence; physician availability). Certain reports that include 2013 NHIS data will serve as pre-2014 baseline estimates (i.e., financial burden of medical care; strategies to reduce prescription drug costs; clinical preventive screenings; adult emergency room use; physician availability). Additional topic suggestions are welcome.

**Discussion** With regard to the ACA, it is important to present meaningful change in the uninsured rate and to develop a plan to learn from the field. Estimates are based upon people going from uninsured to insured status through the marketplace; from private insurance to the marketplace; or from uninsured to Medicaid. The challenge is to untangle coverage changes. Questions addressing these challenges have been added to the 2013 and 2014 NHIS surveys. Will the uninsured rate change because of the marketplace or Medicaid expansion? Along with other federal agencies, DHHS is trying to look more broadly at coverage based on income levels. A discussion of survey question content will be ongoing. Early data and an initial quality review will evaluate the response to survey questions and determine whether the questions or the developed algorithm need modification.

A big contribution by NHIS would be to sort out coverage type and determine whether the uninsured rate is differentially changing across state groups using different policy approaches and across income groups. There may be many exceptions to coverage types. It will be difficult to determine at what point it makes sense to modify survey questions and when to use split samples. A suggestion was made to develop retrospective panels that examine such issues as financial burden and adherence to medications in addition to coverage questions from the previous year. While NHIS has added ACA questions, most insurance questions have not changed since 1997. Questions have been formulated to allow participants to respond accurately within certain timeframes. A sample follow-back survey is being tested as a pilot.

Drug cost survey questions examine what people do because of limited financial means. Given funding reductions for NHIS survey expansion, a suggestion was made to insert some key questions in the CPS or annual social economic supplement. In response to a question about differences between health insurance coverage data from Census and NHIS, it was noted that the NHIS point-in-time data are closely matched to the ACS estimates. ACS does not have much information about insurance type although their survey questions will change dramatically in March 2014. Numerous insurance rate estimates are forthcoming, which will be difficult to evaluate.

An interagency working group meets regularly to determine the best ways to “crosswalk the measures” and to examine the marketplace and different ways of reporting involvement through Medicaid. Surveys such as the Current Population Survey (CPS) and the American Community Survey (ACS) are being conducted by different agencies or within the same agencies, producing estimates in different ways. NHIS provides all other health data and CPS has a longitudinal component. The Bureau of Labor Statistics will add questions to their consumer expenditure questionnaire. There are differences in the questions; changes in some questions; and changes in sample sizes due to funding, so looking for trends across surveys may not be useful. In addition, the data must be “crosswalked” with CMS and state administrative data sets. The Medical Expenditure Panel Survey’s use of the NHIS sample allows for a more detailed look at changes. Further NHIS specifics were discussed.

## **NHIS Design Changes Update**

Christopher Moriarity, Ph.D., Mathematical Statistician, DHIS

Dr. Moriarity provided background about the sample design periods and reviewed the sample design timeline currently underway, noting a big change in the 2016 sample design (new source of sample addresses). He reviewed historic NHIS sample design features and the motivation for periodic NHIS sample redesigns, citing recent sample redesigns with relatively minor changes (1995-2005; and 2006-2015). He then addressed the 2016 sample redesign, noting several major changes (e.g., more flexibility to change overall sample size or allocations by state from year to year; and a new source of sample addresses, namely commercial address lists).

Other demographic surveys conducted by the Census Bureau are moving toward using the Master Address File (MAF) as the main source of sample addresses. NCHS has shared costs for NHIS field listings but does not want to use MAF addresses for NHIS (which cannot be shared) so as of 2016, NHIS will use one or more commercial address lists as the main sample address source. The 2016 NHIS sample design will include some field listings (e.g., in certain rural or large apartment situations). NHIS milestones include the definition and selection of primary sampling units (PSUs); and the acquisition of a national address list. Future milestones were also delineated.

**Discussion** Many commercial lists are accompanied by other identifying information (e.g., age, ethnicity) for additional fees although the quality of that information is unknown. Such information will be collected and used for NHIS design from the previous decennial census or ACS data at a geographic rather than individual unit level. The MAF is national rather than restricted to NHIS sample areas. An agreement that allows the Census Bureau to share information about small area estimation research may finally be in place. There is some interest in acquiring future access to the postal service delivery sequence file (not for sale on the open market) for use in addition to the commercial address list. The address lists being developed for emergency services might be the better list.

No funding exists for an independent evaluation of address list quality but a strategy is being developed to do some form of evaluation. Specific personal information such as names and addresses are not being acquired at this time. It was suggested that emergency response information (a more open source for geocoding purposes) might be a way to obtain specific address information in the future. The precise impact of foreclosures on the effectiveness of the listings is unknown. Oversampling in large apartment buildings or gated communities has not been used as a strategy thus far.

## **NHIS Questionnaire Redesign and Content Changes – Interactive Session**

Stephen Blumberg, Ph.D., Associate Director for Science, DHIS

Marcie Cynamon, M.A., Chief, Survey Planning and Special Surveys Branch, DHIS

### **Presentation and Discussion**

The 2017 NHIS questionnaire content redesign (the first since 1997) is intended to better meet current data needs; improve response rates; reduce respondent burden; lower costs; and improve state-level estimates as budgets permit. Downward movement in family, adult and child response rates has been evident since 1997. Interview time (2013) is up by twenty

minutes since 2001, which may be connected to poorer response rates (although not solely). The questionnaire redesign timeline was outlined.

Discussion topics for the BSC included: identification of key stakeholders; process for seeking public input; process for identifying priorities and choosing among competing priorities; consideration of questionnaire structure, alternative modes of data collection and impact of redesign on trends; assistive roles of outside entities; and the BSC's role. Key stakeholders were identified and input was requested relative to outreach; structure of information solicitation; the regulatory (OMB) process; and balancing early or general input versus later or detailed input.

A question was posed about the process for reducing questionnaire length; and about how to determine whether additional questions add depth to information gathered. The quality of information depends upon factors such as cognitive testing and how long a content area has been in the survey. Audit trails and other paradata lend understanding to how the questionnaire is navigated. Using external comparisons such as medical records for quality assessment is more limited than internal reviews. There must be agreement on a minimum dataset and timeframe for its use.

Noting a need to contain the supplements and the core of surveys, what supplements are supported annually by NCHS? What incentives exist for survey participation? The public is more likely to care about supporting programs at the local level. What process is in place to determine relevant priorities about lower costs and lower burden? A cost and benefit analysis is needed. With no expanded sample size, there is great benefit to combining adjacent years of survey data. Increasing sample size may lose some trend details but this is an important trade-off. Redesign is needed because the current survey is too long.

It takes a long time to redesign income questions, which very much need updating. Should the Census Bureau assume responsibility for income information-gathering or should a few basic income questions be included in the surveys? One participant noted that income is a problematic variable relative to inflation, noting inadequate focus (and therefore decreased survey usability) of health outcomes among people at the top. Noting positive correlation between income and health, this notion was challenged by another who indicated a greater need to gather more information on lower income levels.

A more flexible redesign will provide choices regarding mode or sample size. A telephone component will be added to supplement the sample size (although some content will be sacrificed). The recently redesigned Canadian Community Survey uses internet and phone data collection and a shorter questionnaire. They use a rotating core with two- and one-year themes, rapid response for urgent issues and sometimes three- or four-year themes. Such a system could work if every few years, correlations between questionnaire variables are gathered. It will be useful to learn from their process. A description was provided of the California Health Interview Survey (CHIS), which uses a core set of questions (and others added by funders).

Discussion ensued about modifications and possible alternatives to the current questionnaire structure. Priorities must determine what remains in the surveys and what is deleted. A process must be developed to resolve competing priorities and to identify appropriate measurement periodicity, whether annual, biennial or less often. Optimizing within areas with a common set of stakeholders who choose between objectives is more feasible than optimizing

across different areas (i.e., how do they want to allocate between frequency, sample size and length of their section?).

It is important to refresh understanding about why participating in these surveys is important. Would responsiveness increase with greater choice about internet, phone, face-to-face or a combination for interviews? DHIS is preparing reports that address these questions. Would questions work the same within different modes or for varying amounts of time? The NHIS is considering an expansion of state-level estimates with shorter questionnaires to be used as supplemental samples within primary sampling units. Because constituencies exist for each question asked, decisions about what to cut can have political implications.

Other topics briefly discussed included: a recommendation to place access measures into sample adult and child files for state-level estimates; and why the BRFSS is not useful to the NHIS survey relative to small area estimates. There has been huge growth in non-health issues or demographics rather than in health measures and, as such, non-health survey questions have significantly increased. Should the area of family composition be replaced? It was noted that the sickest and poorest people have the longest surveys. While the NHIS questionnaire is not the survey-of-record for income, a better job can be done of gathering information about analytically important groups. Despite NHIS's status as the gold standard for health interview surveys, concern about the declining response rate was reiterated. Determining who refers to and links to the NHIS data will provide meaningful information about user distribution in different categories for different data types.

The questions raised provide a good opportunity to rethink the survey's primary goals and to develop evaluation criteria for more systematic results. Criteria might include consideration of whether issues are relevant health problems or emerging problems that should be characterized; whether trend data are needed; whether measurements are being collected elsewhere; and what supplementary key data like race and ethnicity are needed. Input should then be solicited to address the criteria. A strawman questionnaire could facilitate communication with users and gathering feedback. Discussion about the pros and cons of a clean break or a bridge year launch ensued, noting no bridge to the new 2016 sample. Relative to assistive roles, improvements made by using contracts, agreements or outside partners are best determined in-house.

The BSC's role in the NHIS was further discussed. An appropriate role would be to provide general guidelines rather than addressing specific issues (although it was also suggested that generalities might not be useful). The BSC might help develop processes and criteria; and then help to evaluate whether reasonable processes have been used (e.g., in making the income section more concise). The BSC could also provide input and advice to the NHIS program strategic planning process. In any event, the BSC should be informed of major NHIS decisions. To maintain transparency, a suggestion was made that the BSC sign off on questionnaire recommendations and adjustments, which are then documented. Quality is a top concern followed by timeliness, noting that demographic areas represent the biggest growth areas. In order to sign off as a Board, BSC members must understand the decision tree. BSC can best offer endorsement of a structure and a process.

### **Assessing and Improving the Quality of Birth Certificate Data**

Mark Flotow, M.A., BSC Member and IL Center for Health Statistics

David Justice, B.A., Statistician, Data Classification, Acquisition and Evaluation Branch

Joyce Martin, M.P.H., Lead Statistician, Reproductive Statistics Branch, DVS

Hetty Khan, M.G.A., M.S.N., R.N., Health Informatics Specialist, NCHS

**Presentation I** Mr. Flotow addressed birth rate quality in his presentation. He defined vital records relative to its history; what is covered; who is responsible; major uses (public health and research; legal and administrative); processing; birth and death registration data flow; federal partners; and needed improvements, namely data quality and timeliness.

**Discussion** Attention to improving fetal death data is as important as improving birth data. The quality improvement process encourages states to accept the standard definition of certificate for late fetal deaths as well as live births. Several years ago, states were sent an algorithm developed by NAPHSIS and DVS to help hospitals and physicians better report and understand the difference between reporting fetal death, live birth and induced pregnancy termination. One DVS workgroup has been developed on birth and fetal death reporting while another is working to improve fetal death data reporting. NAPHSIS is trying to get its membership interested in forming a fetal death data quality workgroup. Within cause of death reporting, there are new ways to ensure that abortions are not included in fetal death data. Challenges to obtaining accurate data were discussed.

Fetal death reporting is the responsibility of the hospitals but funeral home directors are responsible for filing death certificates. As such, there could be confusion about what is a fetal verses a live birth infant death, resulting in over reporting of perinatal mortality. The challenges of under reporting, over reporting and high levels of non-reporting were mentioned, including different definitions and substantial misestimating of racial disparities.

**Presentation II** Mr. Justice and Ms. Martin focused on assessing and improving the quality of birth certificate data. Topics included the role of DVS's Data Acquisition, Classification and Evaluation Branch (DACEB) in evaluating birth data quality, basic birth data processing, quality control verses specialists, the role of statisticians relative to quality control and DACEB statistician interaction with states. An introduction of NCHS's reproductive statistics branch (RSB) followed. The 2003 birth certificate revision was reviewed, most notably its primary goal, standardized worksheets, detailed specification for electronic systems and a guide to completing facility worksheets. The impact of the revision and reengineering were delineated relative to improved quality of birth data, including initial challenges and timeliness. Recent efforts to assess and improve data quality were described, including interviews with birth information specialists, validity studies, checkbox items with high and low sensitivity items in two states, additional efforts to evaluate data quality, description of a birth data quality workgroup and subgroups and a summary of findings. Near future plans include e-learning training available to all birthing hospitals; improved information on quality of data items, with poor data items dropped from the national standard; and a standardized improved approach to assessing hospital specific data. Progress in 2003 birth certificate revision adherence was demonstrated in 2012-2015 maps of state birth estimate revisions.

**Discussion** Clearly, death certificate race data on mortality is not self-reported. Birth certificate data, reported by the mother, are believed to be very well reported. It is better to examine linked birth and infant death files when examining infant mortality data by race. The medical record is presumed to be the gold standard for data collection.

**Presentation III** Ms. Khan addressed the potential impact of electronic health records (EHRs) on birth medical/health data. Mother and infant medical records are recommended sources of vital records (VR) data for more than half of all VR data collected on the U.S. Standard Certificate of Live Birth and Death and at the U.S. Standard Report of Fetal Death. While it is worthwhile to gather VR information from the EHR, debates about using EHR information

continue. Assumptions must be tested and a foundation laid for gathering EHR information. A hypothesis about improved timeliness, accuracy and quality was presented to support engagement in an eVital Standards Initiative. NCHS stakeholder engagement and standards development activities were described, including testing and demonstrations. Wider testing and evaluation are needed to assess data quality with revisions made according to findings.

**Discussion** This first operational effort to extract EHR information is widening to include transferability to vital records. Although EHR implementation starts at the state level, it will become a hospital-specific issue. Data from EHR and paper records should be consistent. Only medical and health data (not demographic) will come from EHRs at this stage. Vital record data, considered to be high quality due to their completeness, are tied to legal and administrative documents that can be enriched by EHR data. However, this will only happen with specific ties to benefits. EHR adoption is becoming widespread; and electronic systems in the clinical arena are shifting into the norm. The issue of how to correctly link clinical to legal information with undocumented populations was raised.

A discussion about international data registration ensued. UNICEF wants all child births to be registered. However, expertise is generally lacking for running civil registration systems. Birth and death registration systems in South Africa, Malawi and Kenya were described. Every country needs help with cause of death coding. International collaborative efforts were delineated (e.g., use of automation for cause of death coding and mortality statistics; IRIS). It could be problematic to use hospitals as the gold standard when working to improve prenatal care records due to bias in data quality toward full-term, uncomplicated pregnancies. While the hope is that pre-populated information within a labor and delivery summary would already have been gathered electronically, this contention requires testing.

A question was posed about how to deal with low quality items with little chance of improvement such as standard certifications. States decide whether to collect them but it is unclear whether the topic of gathering data perceived as not useful should be addressed publicly. A DVS workgroup of vital statistics experts are addressing such questions in collaboration with colleagues from DOH, NAPHSIS and NCHS. A watch list is under consideration. Some EHR data that are probably inconsistently reported at present could be consistently reported with linkage. Some items will and some will not be improved with EHR data.

Emerging birth record items relate to a “hotlist” that includes cesarean delivery and home births. Getting all states onto the new certificate takes priority over changes. In response to a question about EHR data and birth certificates, it was noted that birth certificate information could be collected in a standardized way and that EHRs are still in need of improvement. Without the birth certificate, it is possible to query a de-identified dataset from the EHR that examines the population and produces general prevalence incidence information. However, a public registry allows for de-duplication (counting people once) while querying EHRs does not. Much discussion has occurred about EHRs versus a public health registry. It would be beneficial to integrate EHR and public health registry data but using one without the other presents challenges (immunization registry example given). When things go wrong, there must be a clear understanding of the issues and who has the authority to make corrections. Some questions are better answered in person (behavioral example given). An IOM committee is considering inclusion of behavioral and social measures into EHRs in a standardized way.

The meeting was adjourned at 5:00 p.m.

**Tuesday, January 28, 2014**

**Welcome, Introductions and Call to Order**

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

**Physical Activity in U.S. Youth**

**Results from the NHANES National Youth Fitness Survey**

Tala Fakhouri, Ph.D., M.P.H., Senior Service Fellow, NHANES

Overviews of physical activity benefits and the 2012 NHANES National Youth Fitness Survey (NNYFS) were presented along with American physical activity guidelines. NNYFS objectives, sampling design and in-home interviews as well as the Mobile Examination Center (MEC) and results were described. The first nationally representative data on core upper body and lower body measures of muscle strength were delineated (Measures of Muscular Strength in U.S. Children and Adolescents, 2012). Conclusions included no significant differences between the sexes in younger children; more strength in adolescent boys than girls; and more strength in adolescents than in younger children. The Physical Activity in U.S. Youth Aged 12-15 Years 2012 data brief and conclusions were presented, noting that about 1 in 4 U.S. youth met national physical activity guidelines. Unpublished data about television and computer use as related to obesity and inactivity were discussed. Survey results are intended for the development of programs and policies and for the development of national reference standards.

***Discussion*** Funding restrictions curtailed some NNYFS household sampling while some data were gathered from NHANES and NNYFS participants. The NNYFS interview was much shorter than the NHANES interview. NHANES participant selection depends upon such factors such as income and ethnicity while NNYFS depends upon sex and age, making data less expensive to gather. These independent samples could be used together. "Fifth trailers" using the same infrastructure could add content to surveys. This has worked well for NNYFS and NHANES but not as well for 24-hour urine collection.

In some cases, NNYFS measures were examined for race and ethnicity differences although not always due to sample size limits. NHANES data show race/ethnic differences for TV/computer use and physical activity as do accelerometer data (which also cover sleep patterns and are the gold standard for physical activity self-reporting). For the first time, muscle strength is being measured at a younger age (3 -11 years) to establish a measures standard and track changes over time (noting that 12-15 year olds self-report and 3-11 year old data are gathered by proxy). Much research supports the notion that level of physical activity and strength tracks from childhood to adulthood. Response rates for NNYFS were above 70% (over 1,500). It is unclear whether physical activity leads to obesity or vice versa. Information about puberty was not gathered for NNYFS.

Contextual data such as playgrounds and other community structures and changes in diet behavior (relative to USDA food dessert data) are not well-defined or established. Linkages with NHANES are geocoded to the residence.

## **Next BSC Reviews**

Virginia S. Cain, Ph.D., Designated Federal Official, NCHS

A major impetus in the creation of the BSC to have an outside group conduct NCHS program reviews. Review protocol and self-assessments (developed by a previous BSC with NCHS input) took a broad program overview to examining capacity; resources; information products; and efforts to improve as crossed by current status/future plans; scientific quality; and responsiveness to user needs. Programs that have been or will be reviewed were enumerated. The BSC was asked to consider future direction. Programs under review generally thought the program assessment to be useful; and some sought advice about particular issues. A summary of possible BSC program review areas was distributed.

**Discussion** A suggestion was made to consider a review across programs and more specifically, to develop metrics (e.g., of timeliness or accuracy) across the whole set of programs. Response rates as a cross-cutting issue must also be addressed. How can NCHS be helpful to the review process? When metrics of use are not very good, it is helpful to refer to BSC review outcomes. Other considerations included questions about how much depth is needed in reviews; how much time between reviews; whether to make reviews more focused; what specific cross-cutting program ideas to incorporate (e.g., response rates; publications procedures); and what besides response rates exhibits quality.

A holistic framework for use across programs might be considered when tradeoffs, increasing demands, limited time and resources are in play. There should be active discussion about big picture questions such as whether state-level data are being used and whether big investments are being maintained. Given long intervals between reviews, are there ways to track progress with identified issues? Despite a several-year program reporting requirement following reviews, recommendations tend to be general rather than targeted. Recommendations made to the long-term care program were followed but that was a unique situation requiring timely change. The ongoing topic of whether NHIS and NHANES should be integrated was raised but thought to be a specific issue rather than a review question.

Programs are responsible for making use of reviews. Programmatic needs were differentiated from agency-level big picture, trade-off needs. A change of the structural review process was offered (whereby programs present an overview but then have an opportunity to raise specific concerns with the BSC). Another suggestion was made to ask programs for input about potential threats to the whole enterprise (e.g., response rates are falling; untrustworthy or slow data), putting individual issues into a bigger context. However, such a review (which might be very technical) would have to be program-specific. It was not seen as an appropriate task for the BSC, although disseminating data more quickly might be worth exploring.

Measuring program value was raised as a cross-cutting question. To address cross-cutting issues, big picture considerations that enhance communication across NCHS divisions must be taken into account. Questions about alternate data sources revolved around where they come into play. The BSC can help set standards, engagement and expectations. A question was raised about key data source factors (that may not be survey data) that would help establish the health of the nation and produce sound statistical data.

The many complexities of eliminating resource duplication (e.g., BRFSS with HIS) were noted. Relative to program reviews, it is valuable to identify accomplishments and challenges. The usefulness of core metrics measureable across programs was reiterated. It was suggested that specific questions developed by programs be supplemented by specific and cross-cutting

questions developed by the BSC. It is important to ensure NCHS's position as a strong player in the data world and to consider the growth of electronic records.

Integrating EHRs with vital records is a "very threatening concept" in that electronic information does not cost and vital records do; and noting that comparable data would no longer be available. Epidemiology is also threatened by EHR use in that longitudinal, population-based studies are much more expensive than EHR information gathering. The critical value of standard epidemiology must be better understood.

BSC reviews serve as a checklist for NCHS in addition to their usefulness to programs. They don't and should not preclude dealing with cross-cutting issues. New processes (such as merging EHRs with surveys and birth certificates) and broad issues (such as changing relationships between programs) could be addressed by the BSC. A model of alternating program reviews with topic reviews was suggested (examples given). Other suggestions included: beginning with one cross-cutting issue to see how it works; alternating a cross-cutting theme with specific programmatic themes; developing a matrix and mapping out a two-year framework (holding off on BRFSS). Mr. Flotow and Dr. Baldwin volunteered to serve on a review committee to process these ideas. Dr. Cain would also like to address NHIS designs; and to consider implications for NHANES. A framework should include multiple surveys, taking trade-offs into consideration. NHIS could serve as a starting point for a cross-cutting framework discussion.

### **NCHS Outreach and Collaborations**

Kassi Webster, M.P.H., Health Scientist, Office of Planning, Budget and Legislation, NCHS

NCHS outreach efforts were summarized, including the overall goal of promoting NCHS data as *the* trusted source for U.S. health statistics. Division-level activities were briefly reviewed but the main focus was on what is happening in the Office of the Center Director (OCD) to increase awareness of NCHS externally (i.e., with Congress via CDC-Washington; partners; and the research community) and internally, to facilitate connections between DHHS and external organizations. Data users and specific outreach strategies and tactics were identified as were challenges (e.g., opportunities for briefings; reaching and engaging a wide range of partners; and limited resources).

**Discussion** Suggestions were made to include outreach to the business world (perhaps through the Chamber of Commerce; and the national business health group); and to develop data sets more focused on teaching and inquiry-based learning in order to accommodate use at graduate, undergraduate and high school levels. Another idea was to advertise in professional association newsletters. A more active presence at the American Public Health Association (APHA) annual conference was recommended in addition to professional organizations like the American Colleges of Statistics and the Association of Schools of Public Health. Every four years, the Society for Epidemiology Research (SER) has a North American Epidemiology Conference that was also suggested for outreach as were the Population Association of America and the American Sociological Association. Other possible avenues are accountable care organizations and payment reform initiatives. NCHS generally has booths at major conferences although current travel restrictions are a constraint to outreach efforts. An intern program exists but is not as active as it once was, again due to staffing and budgetary constraints.

It was suggested that an interactive webinar format would be more useful than website videos about particular topics. NCHS has a Facebook page and a Twitter account (managed by

Information Services) but the number of followers was not known. Social media provides promotion opportunities. For example, when a relevant issue hits the news, a tweet can let readers know to look for specific state data through the NCHS link (noting that clarity about who is able to tweet must be obtained). Compiling a listserv of PUBMED authors and sending links to data briefs might reach more health researchers.

Content syndication was defined, discussed and recommended as a potential outreach tool. For example, content published by CDC can be picked up by another department's website and embedded into their web pages or into a box in a format of choice. Outreach efforts cannot be quantified in a systematic way.

**PUBLIC COMMENT**           None.

**BSC Wrap-Up**

Virginia Cain, Ph.D., Executive Secretary

Follow-up calls will be set up to discuss a review of NHIS content changes with NHIS staff. Developing a framework for making tough decisions about survey content is the next step. Next steps for BSC reviews include examining BSC comments about how to proceed; and scheduling a conference call with volunteer review committee members.

The meeting was adjourned at 11:48 a.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

\_\_\_\_\_7/3/2014\_\_\_\_\_  
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  
Mark Flotow, M.A.  
Hermann Habermann, Ph.D.  
Christine L. Himes, Ph.D. (1-27-14 only)  
Carol J. Hogue, Ph.D., M.P.H. (via phone on 1-28-14)  
Genevieve M. Kenney, Ph.D.  
Thomas A. LaVeist, Ph.D.  
F. Javier Nieto, M.D., M.P.H., Ph.D.  
Stanley Presser, Ph.D. (1-27-14 only)  
Ana V. Diez Roux, M.D., M.P.H., Ph.D.  
Margo Schwab  
Linette T. Scott, M.D., M.P.H.  
David Takeuchi, Ph.D.  
Alan M. Zaslavsky, Ph.D.

#### **Presenters**

##### **January 27, 2014**

Stephen Blumberg, Ph.D., DHIS  
Marcie Cynamon, M.A., DHIS  
Mark Flotow, M.A., BSC  
David Justice, B.A., DVS (via phone)  
Hetty Khan, M.G.A., M.S.N., R.N., NCHS  
Jennifer Madans, Ph.D., NCHS  
Joyce Martin, M.P.H., DVS  
Christopher Moriarity, Ph.D., DHIS  
Anjel Vahratian, Ph.D., DHIS

##### **January 28, 2014**

Virginia, S. Cain, Ph.D., BSC  
Tala Fakhouri, Ph.D., M.P.H., NHANES  
Kassi Webster, M.P.H., NCHS

## **Others**

### **January 27, 2014**

Irma Arispe, Ph.D., OAE, NCHS Staff  
Clarice Brown, M.S., Director, DHCS, NCHS Staff  
Verita Buie, NCHS/OPBL  
Pei-Lu Chiu, NCHS/DHIS  
Richard Coles, NCHS/DHIS  
Jim Craver, NCHS/OAE  
Jim Dahlhamer, NCHS/DHIS  
Christina Dragon, NCHS/OAE  
John Dolinka, NCHS/OIT  
Alan Dorfman, NCHS/ORM  
Jane Gentleman, Ph.D., Director, DHIS  
Renee Gindi, NCHS/DHIS  
Brady E. Hamilton, NCHS/DVS  
Lauren Harris-Kojetin, NCHS/DHCS  
Cathy Hess, NCHS/OPBC  
Julia Holmes, NCHS/OAE  
Debbie Jackson, NCHS/CPHDSS, NCHS Staff  
Katherine Jones, NCHS/CPHDSS, NCHS Staff  
Sharon Kirmeyer, NCHS/DVS  
Julie Kowaliski, NCHS/DVS  
Bill Mosher, NCHS/DVS  
Hanyu Ni, NCHS/ DVS  
Colleen Nugent, NCHS/DHIS  
Kathy O'Connor, NCHS/DHIS  
Jennifer Parker, NCHS/OAE  
Van Parsons, NCHS/ORM  
Nathaniel Schenker, ORM, NCHS Staff  
Iris Shimizu, NCHS/ORM  
Sandy Smith, NCHS/OCD  
Suresh Srinivasan, NCHS/DHIS  
Makram Talih, NCHS/OAE  
Stephanie Ventura, NCHS/DVS  
Maria Villaroel, NCHS/DHIS  
Sara Warner, CDC/FMO  
Kassi Webster, NCHS/OPBL  
Julie Weeks, NCHS/OAE

### **January 28, 2014**

Yutaka Aoki, NCHS/DHANES  
Brenda Baker, NCHS/DHANES  
Clarice Brown, NCHS/DHCS  
Alexander Dorfman, NCHS/ORM  
Meena Khare, NCHS/ORM  
Michael Martinez, NCHS/DHIS