

Department of Health and Human Services

Board of Scientific Counselors

September 19 - 20, 2013

NCHS Auditorium
3311 Toledo Road
Hyattsville, MD 20782

Meeting Minutes

The Board of Scientific Counselors was convened on September 19-20, 2013 at the National Center for Health Statistics in Hyattsville, MD. The meeting was open to the public.

MEETING SUMMARY **September 19 - 20, 2013**

(Please refer to PowerPoint presentations for further specifics)

ACTION STEPS

- BSC members were asked to send comments and questions about the upcoming NAS meeting.
- A determination should be made about how to structure the next round of program reviews in the next BSC meeting.
- Topics suggested by BSC members will be examined to determine what can be developed for the January 2014 meeting.
- A request was made for regular updates on how the HIS and other survey questions unfold.

Thursday, September 19, 2013

Welcome, Introductions and Call to Order

Raynard Kington, M.D., Ph.D., Chair, BSC
Jennifer Madans, Ph.D., Co-Acting Deputy Director, NCHS

NCHS Update

Jennifer Madans, Ph.D.

A budget update was presented, noting the uncertainties of the 2013 budget. New hires and retirements at CDC and NCHS were recognized. The Office of Public Health Scientific Services is being reorganized to house NCHS and the Center for Surveillance, Epidemiology and Laboratory Services (CSELS). Program updates covered: the Division of Health Interview Statistics, noting the release of 2012 NHIS public-use microdata files on June 28, 2013; reports on new NHIS content; 2013 National Health Care Interview Survey; use of the ACS to expand the NHIS sample of Native Hawaiians/Pacific Islanders; planning for the NHIS redesign sample, content and mode in 2016 and 2017; NHANES and their upcoming reports (data release in early October 2013); activity in the Division of Health Care Statistics and the Division of Vital Statistics; recent DVS publications; the new release of linked mortality files; the soon-to-be released Interactive Health, United States 2012; joint statistical projects with the Census Bureau; Research Data Center news; and the fifteenth annual interchange with Statistics Canada in November 2013.

Discussion The 2007 fetal death files were recently released. The next release will possibly combine the files with a report. NCHS is participating in an OMB group to examine plans for collecting race and ethnicity data. Changes in the data collection would affect the decennial Census and the American Community Survey (ACS) possibly going into effect in 2018. Addressing race and ethnicity within vital statistics will become increasingly complicated.

As of October 1, 2013, NCHS would like information about health insurance applications on the Exchange, acknowledging the starting point for a work in progress. First quarter insurance rates will occur in the fall of 2014 (NCHS's standard early release insurance report is forthcoming). While it would be helpful to link CMS enrollment data to the HIS, it is not likely to come in real-time. There are many unknowns and much confusion is expected in the short-term.

At the state and federal levels, there should be an examination of: the way that data are collected on forms; how the forms get integrated into EHRs; and requirements about Meaningful Use, Stage Three (California example given). Different EHR needs were noted. The push to make Exchanges look like private insurance may cause problems with data link-back.

Coming Attraction: The NHIS's On-line Analytic Real-time System (OARS)

Jane F. Gentleman, Ph.D., Director, DHIS

Jacqueline Lucas, M.P.H., Health Statistician, DHIS

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

The general public can now access NHIS data analyses from 1997 - present, including restricted data that cannot be obtained from the public use file. It is a methodological challenge to screen analyses conducted in real time without divulging identities. Information requests must pass DHIS scrutiny. Confidentiality methods that meet rigid federal government standards have been developed. OARS will look much like AskCHIS (California's on-line analytic system for the state's HIS data) as it is based on the same user interface adapted for the NHIS. This tool is another way for users to analyze HIS data (in addition to public use files; Research Data Center data; and a preliminary micro-data file with HIS data, available in Research Data Centers). Development of the OARS system was in response to ASPE's need for more and faster access to state-level estimates, especially with the Affordable Care Act.

Although merged, there are two underlying micro-data files in the OARS's system (Subsystem P, with only public data use; and Subsystem R, with some restricted variables such as state or race/ethnicity). Trade-offs were mentioned (e.g., in Subsystem P, users never see underlying micro data; and in Subsystem R, users never see weighted results). In order to protect confidentiality, analyses will be imperfect. Users who receive a significant number of denials in one sitting will be given suggestions about how to proceed for better results. Two other methods designed to protect confidentiality are the perturbation of underlying micro-data files, which still yield a reasonable, useful analysis and screening in real time.

In this second version, OARS data begin in 1997 following a major questionnaire redesign and the start of CAPI use. A third OARS version is imminent. Ms. Lucas demonstrated features of the OARS tool. (*Refer to OARS report in addition to PowerPoint of September 19, 2013; transcript; and "Addressing Disclosure Concerns and Analysis Demands in a Real-Time Online Analytic System" by Tom Kranzke, Jane F. Gentleman, Jianzhu Li and Chris Moriarity, Journal of Official Statistics, Vol. 29, No. 1, pp. 99-124*)

Discussion Perturbation, which introduces non-sampling error, was further discussed. Methods and levels of perturbation are confidential. The OARS tool provides researchers with quick access to more information than is currently available from public use files. Some perturbation is applied to restricted variables before they go into the system while several methodologies (e.g., swapping; rounding; subsampling) are used in real time after a user submits a query involving a restricted variable. Running multiple cross tabs yields the same result. It was noted that what might look like state estimates are not because the approval process is not yet completed. Target OARS users include a wide audience but are primarily policymakers. The next program iteration will have defaults as well as additional choice options. Parts of the system have been made simpler for lay users.

It is important for sophisticated policy users to understand the difference between actual estimates using perturbed versus unperturbed data. A comparative summary report could be made available to the policy community. Participants were asked to define what would go into a user-friendly report for mid-range users. OARS may allow some users to skip the RDCs; others denied in OARS will use RDCs.

National Academy of Sciences NHANES Workshop Recap

Virginia Cain, Ph.D., Executive Secretary, BSC

A brief history of the NHANES DNA Bank and benefits of NHANES DNA analysis were presented along with a description of the NHANES genetic program evolution. Examples of consent statements related to DNA were put forth. There is ongoing debate about what is ethically appropriate to return to respondents with genetic results. Relevant advances in genetics were noted including an increased potential to identify incidental clinically relevant findings, noting that blanket non-disclosure is not appropriate. Highlights of the May 2011 NHANES Genetics Program Workshop were described. The BSC had raised serious concerns about re-contacting participants. Additionally, there were questions about consent form changes (noting a need to pre-test what a consent should be); and concern about outreach to other organizations relative to impact on other surveys. On June 11, 2012, a Federal Register Notice stated that NHANES would not receive DNA proposals in the near future. Next steps include a broader, collaborative discussion of the issues (e.g., with several IOM and NRC committees). The National Academy of Sciences will hold a workshop entitled, "Guidelines for Returning Individual Results from Genome Research Using Population-Banked Specimens" (no date mentioned), out of which, a document (but no recommendations) will be produced.

Discussion The question of whether and how to re-contact people associated with banked specimens (as opposed to future specimens) was raised, considering that some specimens are twenty years old. Currently policy is not to re-contact; and addressing the policy question is not likely to yield a consensus. How long specimens should be stored also remains unresolved. The hope is to come to consensus with other population surveys but it is more likely that issues will be further clarified but not necessarily resolved.

In response to a question about whether cost, practicality and the difficulty of follow-up will be addressed by the expert panel, it was noted that cost is not the focal point.

Public Health Data:

The Role and Vision for the Office of Public Health Scientific Services

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

The Office of Public Health Scientific Services (OPHSS) holds the National Center for Health Statistics and the new proposed National Center for Epidemiology Surveillance and Laboratory Services. The common unifying theme is data. New to the Office of Public Health Scientific Services, Dr. Chesley shared his background and focus on the interface of health care and public health. NCHS's status as an independent statistical agency must be protected. Three principles to focus on include: data as a unifying theme; the need to be customer-centric, particularly in relation to CDC programs; and the need to be innovative, creative and practical.

Priorities of OPHSS include the creation of better data access, lab integration, and surveillance integration. Four key issues in the draft strategy for surveillance (to be presented to Dr. Frieden on December 12, 2013) are: to increase the availability and timeliness of surveillance data to CDC programs as well as to state, local and territorial health agencies and other stakeholders, including the public; to advance effective use of emerging information technology including electronic health records, mobile technologies and cloud computing; to identify and amend or retire ineffective or unnecessarily redundant CDC surveillance systems; and to maximize the effectiveness of the available agency resources devoted to surveillance and the performance and coordination of surveillance systems.

Discussion The process of maximizing resources and amending or retiring redundant systems will be focused on CDC systems. Any changes to NCHS will be collaboratively discussed. NCHS can play an important role in using data that point toward prevention benefits and healthy living (e.g., National Health Care Surveys and NCHS's work as it affects the ACA are critical to understanding how to make that interface more effective).

How can NCHS help define what measures change outcomes? NCHS must be part of CDC discussions about how to measure and improve population health; and then, how to incorporate data into various other measurement schemes (i.e., how to validate data collected through clinical systems with similar data collected through population surveys). The hope is to foster a strong and mutually beneficial relationship between NCHS and the Office of Public Health Scientific Services.

Office of Analysis and Epidemiology Review

Irma Arispe, Ph.D., Director, OAE

David Takeuchi, Ph.D., BSC Review Liaison

Linette Scott, M.D., BSC Review Liaison

Donald Steinwachs, Ph.D., OAE Review Chair

An OAE overview was presented, including principal program activities such as: monitoring the health of the nation; providing data and analytic support to HHS and the public health community; expanding the analytic utility of NCHS's data systems; developing data systems and analytic tools for health and healthcare research; disseminating data electronically and developing tools for disseminating measures and data such as *The Health Indicators Warehouse*; *Health Data Interactive*; and the *NCHS Survey Measures Catalog*; participating in interagency and international data development collaboration; and conducting cross-cutting research on public health and statistical methods. Production of the congressionally-mandated report, *Health US* and the *Healthy People* (trends book for Congress focusing on the translation from developmental to measurable objectives) was described. NCHS's role in harmonizing quality with public health measures was recognized. Research collaborators were identified; and research related to clinical recommendations, informing policy, disparities, linked files and methodology were briefly delineated. OAE's organizational structure was presented. Priority issues were identified relative to health policy, budgetary, Executive Branch, CDC and NCHS considerations as were ongoing OAE challenges.

Input is requested from the BSC about issues and questions to be represented in the reviews. Considerations might include: data demands regarding the ACA and whether plans have been made to meet such demands; development of a firewall that prevents politics from infiltrating data demands and priorities; and how to prioritize resources for collaborative projects and innovations. Also mentioned was the importance of linking to the National Quality Strategy (notably, in the public health arena) as well as to the National Prevention Strategy.

A question was raised about how to share success stories in measurable ways about EHR adoption and the transformation of clinical data into structured data. The link between primary care and public health integration was raised as another consideration. The question of how to identify measures that drive outcomes was reiterated. Workforce concerns include what job classifications to use when, for example, no informatics job classifications in state government exist. Workforce recruitment and retention must be strategic.

The reviews present an opportunity to examine increasing income (and therefore health and health outcomes) disparities. There is much concern about the shift from block grants to pay-for-service for mental health and substance abuse treatment. NCHS's work to begin state estimates is a powerful tool for the future. The Affordable Care Act reminds us that using health care and changing behaviors takes time; and it targets areas where access could be improved or behaviors changed. The question of how many resources should be put toward data analysis was posed: should universities do the data analysis to free up time to address methodological concerns such as linkage and improving dissemination?

Discussion The current review is specific to OAE while the next review may encompass a broader scope. Reorganization issues were mentioned. The priority of the reviews is to get feedback on relevance. Key considerations include: what to ask; how to ask; and how to conceptualize what to measure across a broad spectrum of concerns. Taking the dimensions of quality and error into account, “coherence of programs between the parts” is important to consider for the next round of reviews.

In the previous review, development of a strategic plan with objectives was recommended. In contrast, the current review has strategic objectives. A question was posed about whether to focus less on what agencies do to collect data and establish data collection systems on population measurement of health and health care; and focus more on integrating data not designed for that purpose that might also be mined. OAE plays a central role in measures development and data linkage. It was suggested that the Review Group determine priorities about primary data sets to link (e.g., a primary care provider’s ability to obtain a profile about the social and physical environment of a discharge patient).

A September 19, 2013 letter to Charlie Rothwell (Acting Director, NCHS) from Raynard S. Kington, M.D., Ph.D. (Chair, NCHS Board of Scientific Counselors) about the OAE Review was referenced, noting recommendations in the Panel’s report and additional points for consideration.

Big Data: Uses and Limitations

Nathaniel Schenker, Ph.D., Director, ORM

The presentation covered a range of topics including definitions of big data (or lack thereof); advantages and disadvantages of big data; skills needed for big data; current and potential uses of big data (excluding administrative data) in the federal statistical system in the Bureau of Labor Statistics and also, potentially, in NCHS, the Bureau of Economic Analysis and the Census Bureau; Robert Groves’ COPAFS presentation (and his recommendation to blend big data and survey data); recent work at NCHS on blending data and lessons learned; Viktor Mayer-Schoenberger and Kenneth Cukier’s book entitled, “Big Data: A Revolution That Will Transform How We Live, Work and Think” (2013), noting the usefulness of big data in combination with survey data (e.g., for small area estimation); and questions for discussion.

Discussion Because big data are unreliable, survey data should check big data rather than vice versa. Some situations use auxiliary data for which errors do not greatly matter (e.g., business big data applications are used as prediction models, which can be done with errors and predictions). A distinction must be made between situations for which errors in predictions can be used or not. Why, for example, did Google search information predict the flu one year for CDC but not the next? Can studying these outcomes improve methodology?

Big data can complement current surveillance systems but can they add something? In part, this depends upon the speed at which data are obtained and used. With big data, timeliness may trump accuracy and accordingly; certain national estimates may or may not be true. Big data are seductive to the public and to policymakers but attention must be given to how to deal with a changing environment of blended data. NCHS can help to determine what big data are valuable. Big data may provide predictive value even without being precise so the question becomes, how does that data be used? Big data provides context and insights for survey data.

Rather than focus on blending data, why not think about using complementary information sources (i.e., using mixed quantitative and qualitative methods that enhance data)? A discussion ensued about how this would be useful outside of the business arena. At the small area level, summaries could be linked with survey units to enhance scientific value. An example was cited of a state using big data for market research although it was noted that much market research data are reprocessed Census data.

Big data challenges include: lack of transparency and sometimes the will to be transparent and attempts by some businesses to monetize data. Myths about big data include: big data have clear definitions; big data are new; big data are revolutionary; big data are better; and big data mean the end of scientific theories. There is a fear that bad data will drive good data out of circulation. On the other hand, there are ways to use big data not as substitutes for real data but, for example, to obtain public response. They can provide qualitative information that varies over time about trends and non-representative national conversation. The formation of social media focus groups has value.

In order to move forward, data language must be refined in that different examples have different characteristics. The belief that administrative data are “old hat” was refuted and real progress has been made on making use of them in the past five years. Promising data sources should be defined and discussed with regard to use. Some computer science statisticians believe that the term has been overused and that the concept of big data is “passé”.

Could NCHS determine how to leverage administrative data as a big data source? It would be valuable for NCHS to determine the credibility of quality measurement reporting through meaningful use measures relative to what is reported in the registries. In addition, there is a role for NCHS in providing feedback through cross-governmental programs relative to data quality, correctness and potential use. Analyzing, evaluating and processing data effectively take an enormous amount of time. It is important to understand what strengths and limitations the data have for knowledge creation.

How will NCHS plug into discussions about the development of a data infrastructure for patient-centered outcomes research? Other considerations include turf issues and the importance of links when following patients. While some surveys adjust their materials, a major redesign is needed (which can only happen when information can be gathered from EHRs). NCHS has a role in educating the public about the benefits of precise data and the dangers of imprecise data. An educational approach is needed, perhaps in conjunction with an academic partner or a workgroup.

According to a survey methodologist, some big data do not have more severe problems than conventional survey data. The proportion of useful big data will grow over time. All the statistical agencies will have to confront what to do about big data and how to incorporate them over time although none seem to have the in-house expertise and resources to make these advances; efficiencies might be gained by working together. No data are better than wrong data but policymakers believe that some data are better than no data.

The “right order of operations” is to identify issues and then determine what data are needed to help. It is useful to begin with a question. Big data provide information useful for small area estimates (where survey resources only cover large area estimates). Big data could also play a role in understanding behavioral effects of public health. What can new data sources say about the direction of change and how accurate would estimates be relative to in-depth data surveys? For small local areas, correlations between data sources can be estimated with hierarchical

models. For timely data, the correlation between time series can be examined after the fact. It is more productive to determine what is different about big data than to try to mold them into data that people are accustomed to. It is useful to determine what questions big data can address. There is some concern about the threat big data poses to traditional methods; and a question about how to maintain respect for the value of such methods.

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

Friday, September 20, 2013

Welcome, Introductions and Call to Order

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

Monitoring the ACA with NCHS Data

Clarice Brown, M.S., Director, DHCS

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

(DHCS) The mission of the Division of Health Care Statistics was presented along with a description of the national health care surveys. Examples of survey data collected on provider organizations, clinicians, patients and encounters (e.g., with health care providers, medications and services ordered or provided, diagnoses, reasons for visit, disposition and lab values) were identified as were recent changes to the health care surveys. Building on NAMCS/NHAMCS, the infrastructure is in place to collect data from physician offices, emergency and outpatient departments and community health centers. Characteristics of physician offices and hospitals produce a rich data source to evaluate the effects of ACA in different practice settings. The role of emergency departments within health reform was delineated (167 EDs added to the NHAMCS sample in the five most populous states). The goals of the National Study of Long-Term Care Providers (NSLTCP) were enumerated. The Affordable Care Act gives states expanded opportunities to provide Medicaid-funded home and community services to people receiving long-term care services and support.

Discussion There are many ways to measure health care, including a quality perspective that focuses more on care processes. How do various agencies involved in healthcare quality measurement share the work? Survey integration is a major theme of the Department (examples given). Survey redesigns aim to serve a broader audience and function than reporting general statistics. Outcomes from physician office surveys are not known. Because survey results about primary care capacity are not yet in, it is not known whether the nurse practitioner component suggests a different profile (in the 22 states where NPs can practice independently). Although a sample frame is being examined and a data collection pilot is underway, there is no 2014 implementation funding.

Intense interest about the ER supplement from the five most populous states is anticipated. Those states were funded for the 2012 data collection (the results of which are soon to be disseminated). The sample can be replicated but there is not yet funding to do so. It was noted that the revised NAMCS sample design should allow for early release estimates, although it is easier to disseminate findings from the full year. When annual estimates are disseminated, it was suggested that DHCS provide indications of how things have changed throughout the year.

Because state-level estimates are increasingly important, a question was posed about what plans are in place to increase state and smaller-area estimates. Some prevention fund monies are invested in state estimates; and NHIS's last design allows for some activity, which will continue into the future (and also with NAMCS). Such information is not available at present but might be obtainable from administrative hospital data in the future. Vital statistics can be done at the state level. The only way to reprioritize is to close down a data collection system, which is difficult. Adjustments to NHIS were suggested and allocation changes noted. Methods of obtaining state-level estimates were discussed (e.g., electronic; mail supplements; phone; internet). A suggestion was made to sacrifice some details and focus instead on gathering several key pieces of state-level information.

Is there a way to assess quality of data versus quality of care? Can NCHS identify structures in place to compare such data? DHCS examines the quality of abstracted data from medical records compared to EHR data and data in continuity care documents (CCDs, part of Meaningful Use). The data must be of sufficient quality to enable care quality analysis. In the reproductive field, an analysis of indicated pre-term birth or pre-term delivery would be useful if the data are of sufficient quality. Regarding response rates from practice organizations, physician surveys are 60% or higher (noting a dip when the 2012 pool was computerized). Generally, the surveys are increasing in response rates.

(DHIS) Since 2011, prevention funds have expanded NHIS data collection activities, to include sample as well as questionnaire enhancements; testing and development; new surveys; and data dissemination. Most funding has gone to sample increase with investments in questionnaire enhancements. An uptick in insurance coverage was noted when the Affordable Care Act began. The survey allows for pre- and post-ACA comparisons. An effort is being made to administer an abbreviated NHIS by phone to augment the sample in smaller sample states. A reliable estimate must meet a minimum sample size within states. The National Health Care Interview Survey (NHCIS) was described, including new content compared to 2012. Another effort focuses on improving estimates for Native Hawaiian and Pacific Islanders in the HIS (a one-time survey using the ACS). Most recent published reports (2013) cover adult strategies to reduce prescription drug costs and payment of medical bills. New and updated reports are in the pipeline.

Discussion What is the game plan for assessing the NHCIS (and its use) with its various mode and response rate differences? With regard to mode, web and CATI are the same instrument being administered in two ways. Previous data and the mode present many opportunities. The mode can never be completely disentangled from selection. With regard to method, what has been done may be good enough to combine in order to produce national estimates. The next round will be better.

Testing new questions is a secondary bonus. Never before has there been a longitudinal component to the NHIS. Response rates for the first two months were 50%. A detailed non-response bias analysis can be done. The intent is to make estimates and gather real data about changes at the individual level. To date, only several months of data have been collected, which are not yet weighted. Interviewing will be completed by February 2014, noting that a full analysis plan cannot be developed until the response rate is known.

How will the ACA affect population health and what key domains should be assessed? In part, these issues will be addressed by an enhanced questionnaire in specific areas that track to the Act (e.g., use of preventive services). What other ramifications should NCHS monitor besides changes in health insurance, access to and quality of care relating to population health?

Specific outcome indicators have not yet been identified. Standard measurements are still heavily relied upon when examining ultimate impacts. Other than insurance, not much will happen in the first six months of 2014 but utilization changes may occur thereafter. People should not expect health status improvements by January 1st. State data will be interesting due to dramatic differences. The Oregon Medicaid study showed that coverage, financial and mental health measures responded quickly to the ACA's eligibility expansion.

In the Native Hawaiian and Pacific Islander survey, most of the 4000 sample cases are in Hawaii. A suggestion was made to obtain sufficient samples of Native Hawaiians outside of Hawaii. It was noted that the NHAMCS is a nationally representative sample with data based upon medical records abstraction. Because California and other states already have robust data sets, should national data be gathered from states without such data? Oversampling was not a consideration when the decision was made to gather data from the five most populous states. It would be interesting to compare national to state data.

OMB, ASPE, CDC, NGOs and others are involved in decisions about enhancements and sample sizes. The decision-making process was described. Because ACA funding cycles come from the Secretary, getting to data collectors has been complicated – in contrast to content decisions, which have been straightforward. Much investment has been put toward redesigning the sample to be a list sample. The infrastructure changes will have lasting benefit.

As NHIS moves to include CATI, there may be synergy between NHIS and CDC that would enhance the quality of the sample for BRFSS and save money. There have been some preliminary discussions about synergy between NHIS CATI and BRFSS although differences between the two were noted. Further discussion about content focused on testing activities (one example involved testing vocabulary-related questions on NHIS). Information is needed by health policymakers about a general understanding of Medicaid expansion programs. Confusion reigns about tax subsidies versus tax credits.

Findings from Births: Preliminary Data for 2012

Brady Hamilton, Ph.D., Reproductive Statistics Branch, DVS

The presentation focused on findings about preliminary birth data for 2012 from the National Vital Statistics Reports (Vol. 62; #3; September 6, 2013), noting how well the preliminary data tracks with the soon-to-be-released final results. Live births and general fertility rates were presented from 1920-2011 (final) and 2012 (preliminary). Trends for birth numbers and rates flattened between 2011 and 2012 after decreasing steadily from 2007-2010. Those rates were further broken down to teens, age 15-19 (2012 rates down 6% from 2011), reaching a historic low as it also did for women in their early twenties. Trends in birth rates for women in other age groups were presented.

Births and birth rates were tracked for unmarried women from 1970 and by race and Hispanic origin of mother. Also delineated were caesarean delivery rates (unchanged in 2012 for the third straight year); and pre-term births (declined for the sixth straight year). The low birth weight rate declined slightly in 2012. The number of births in the United States was essentially unchanged from 2011-2012 and the fertility rate declined only slightly. Findings were highlighted in a summary of *Births: Preliminary Data for 2012*. Recent and upcoming releases (including file releases) and special reports were identified.

Discussion When a question arose about the recent decline in births for Hispanic women, a lag was noted with regard to more detailed survey information. The birth data include Native Americans on Indian reservations. The most significant change in the quality of race data has to do with the recent implementation of OMB standards that allow for multi-race reporting. Vital statistics data can be viewed at the county level (to include differences by specific tribes). The addition of new sources of payment information was mentioned and a soon-to-be full implementation of the new birth certificate was noted.

Questions about the teen birth rate were posed with no clear answers. Tracking the youth unemployment rate or economic indicators might shed light on teen pregnancy. A suggestion was made to expand the pregnancy risk assessment monitoring system at CDC. More in-depth information would be available through complementary population information from birth certificates and random samples through PRAMS (an underutilized surveillance system because it is not in every state). A discussion ensued about state-specific differences in cesarean rates.

When speaking with the press, a limited amount of detail was offered, especially with preliminary data from the birth certificate. Generally, the press used the data appropriately but was referred to the Pew Research Center for more information about causal factors. Self-reporting is used with the undocumented population.

The NSFG is included in the reproductive statistics branch to provide contextual information. Survey results suggested the economic effect on birth rates although whether there was true causality was not clear.

BSC Member Priorities

Raynard Kington, M.D., Ph.D.

Addressing confidentiality issues was suggested in the previous BSC meeting. An update on birth and death records was requested. A suggestion was made to change the meeting format in order to increase BSC discussion time by having fewer, more brief but focused presentations. Informational papers could be distributed prior to meetings. A suggestion was made to distribute PowerPoint presentations in advance with brief presentations at BSC meetings, allowing for more discussion time. Participants could develop questions in advance.

Requests were made to further discuss various topics to include: prisons and health; children of incarcerated parents; health data quality versus quality of care; quality improvement of medical records; an update on using death certificates to identify rare events; questions NCHS would like BSC to address; EHR issues around use, quality and integration with current data collection systems; overlaps and redundancies within the different surveillance systems at CDC and elsewhere; interaction between educational and health care systems; and veteran's health. Further ideas should be sent to Dr. Cain.

PUBLIC COMMENT

None

Presenters

September 19, 2013

Irma Arispe, Ph.D., OAE
Virginia S. Cain, Ph.D., BSC
Jane Gentleman, Ph.D., Director, DHIS
Jacqueline Lucas, M.P.H. DHIS
Jennifer Madans, Ph.D., NCHS
Christopher Moriarity, Ph.D., DHIS
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Donald Steinwachs, Ph.D., OAE Review Chair

September 20, 2013

Clarice Brown, M.S., Director, DHCS
Marcie Cynamon, M.A., DHIS
Brady Hamilton, Ph.D., DVS

Others

September 19, 2013

Norman Ahluwalia, NCHS/DHANES
Michael Albert, NCHS/DHCS
Juan Albertorio, ISP
Sandra Decker, OAE/SPB
Debbie Blackwell, DHIS/DAQAB
Kelly Brown, DVS/RSB
Mary Ann Bush, OAE
Pei-Lu Chin, DHIS
Jeanetta Churchill, OAE
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Kim Daniels, DVS/RSB
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Laurie Pratt, OAE
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Howard Riddick, DHIS/NCHS
Sandy Smith, OCD
Anjel Vanratian, NCHS

Judith Weissman, OAE
Kassi Webster, NCHS
Julie Weeks, OAE
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September 20, 2013

Cory Blackwell, NCHS/DHCS/TSB
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