

Responses from DHANES to additional information requested

1) Please provide any in house documents on NHANES/NHIS 2013 redesign.

There are no official in house documents as yet, and NCHS is just beginning internal discussions on this topic.

2) Is there any documentation of the positives/negatives of a NHIS and NHANES linkage -- both substantively and financially? Have the perceived benefits of the survey linkage of NHIS and MEPS been evaluated in any systematic way? And, if so, was there any written documentation?

There is no recent documentation on these topics. NCHS can discuss this further at the November meeting.

3) Provide different budget scenarios that have been considered by NHANES, i.e., what are the effects of possible changes in program on budget and vice versa? What are the costs and benefits of oversamples vs. increasing the regular NHANES sample?

The budget scenarios in the separate powerpoint file have been updated since the full BSC met in April. DHANES received more funding from collaborators than anticipated in 2008, so the scenarios have been revised with final numbers. Other scenarios were considered, but we have presented only those that offer more substantial savings. We can discuss those others in person if you wish. Please see the powerpoint file named NHANES Budget Scenarios handout Nov 08v5.ppt

As a prelude to responding to questions 4 and 5 it is important to note we feel the mission of the Division (DHANES) is more encompassing than just NHANES. The next two questions refer just to NHANES and are answered as such. However the program staff defines the broader mission of the Division to include Community-HANES, Longitudinal NHANES, domestic and international collaborations on examination surveys, and significant roles and responsibilities in the areas of nutrition monitoring, environmental biomonitoring and genetics. We would welcome a discussion with the committee on this broader definition of the “main objectives” of the “Program”.

4) What does the NHANES program staff see as the main objectives of the NHANES?

For many years we have stated that the overall objective of NHANES (under the current model) is to assess the health and nutritional status of adults and children in the United States.

Similarly, we have defined the major goals of the current model of NHANES as:

1. To estimate the number and percent of persons in the U.S. population and designated subgroups with selected diseases and risk factors,
2. To monitor trends in the prevalence, awareness, treatment and control of selected diseases,
3. To monitor trends in risk behaviors and environmental exposures,
4. To analyze risk factors for selected diseases,
5. To study the relationship between diet, nutrition and health,
6. To explore emerging public health issues and new technologies;
7. To establish a national probability sample of genetic material for future genetic research;
8. To establish and maintain a national probability sample of baseline information on health and nutritional status.

5) How is survey content determined? What is considered survey core? Is the core sufficient to provide an assessment of the U.S. population? What is determined by funding from outside sources?

How is survey content determined?

The following is a very condensed version of the content development of the NHANES 1999-2010 continuous survey. Survey planning of the content for the continuous survey began in the Spring of 1994 with the objective of data collection beginning in late 1996. Because efforts to solicit proposals for new content hadn't happened since the planning of NHANES III in the mid 1980s a major outreach effort to all potential interested parties was undertaken.

This outreach involved the following elements:

1. Notices in public health oriented professional journals (see example in Reference 5.1).
2. Individual meetings with NHANES III collaborators who might also want to participate in the 1996 NHANES.

3. Letters were sent to leaders at various DHHS organizational units announcing the resumption of planning for a new NHANES (see example in Reference 5.2).
4. Virtually all DHHS agencies were contacted to schedule a meeting to discuss NHANES, its future plans, and mutual interests. Agencies that weren't collaborators then or now such as the Administration on Aging, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid, Agency for Toxic Substances Disease Registry, and the Health Resources Services Administration were met with individually.
5. Most NIH IOCs who weren't NHANES III collaborators agreed to one or more meetings with the DHANES planning staff.
6. CDC CIOs were contacted and meetings were requested and occurred at the Division level.
7. DHANES asked to be on the agenda of as many meetings as possible to present about NHANES plans and to solicit input. Some of the meetings included the Management Committee of the Association of State and Territorial Health Officers, the National Committee on Vital and Health Statistics, and various standing committees at CDC, NIH, and USDA.
8. DHANES planning staff repeatedly discussed future planning at the Nutrition Monitoring Advisory Committee meetings.
9. DHANES planning staff met with Federal agencies outside of DHHS such as the Department of Housing and Urban Development and the National Institute of Standards and Technology.
10. DHANES planning staff met with private entities such as Merck Pharmaceutical and Shape Up America.
11. A special invited forum (see Reference 5.3) of researchers inside and outside the government to provide input into NHANES future was organized and held in 1996.
12. A scientific review panel (see Reference 5.4a and 5.4b) met in 1997 to provide input on the content of NHANES 1999-2000 and future NHANES.
13. Frequent discussion of future plans at the NHANES Consortium meeting. This was a standing meeting that occurred 2-4 times per year since before NHANES III. The meetings lasted until around 2001. The Consortium consisted of all NHANES collaborators and anyone who expressed interest in being continually updated on the status on NHANES. For those who couldn't attend the meetings detailed minutes were widely distributed.

Concurrently we developed guidelines for submitting proposals and distributed them at all meetings and to anyone who expressed an interest. An example of the cover letter is in Reference 5.5 and the original guidelines in Reference 5.6.

By the Fall of 1995 forty-five research proposals had been received. They represented research needs of the following groups:

- 7 CIOs, Centers for Disease Control and Prevention,
- 9 Institutes, National Institutes of Health,
- Environmental Protection Agency,
- Food and Drug Administration,
- Office of Minority Health, OASH,
- U.S. Department of Agriculture.

The proposals were evaluated based on the guidelines by the Planning Branch of DHANES with subject area input as needed from the other Branches and the Office of the Director of NHANES. This was a lengthy process involving meetings and other communications with the proposers. The proposers were usually subject area experts in the area their proposal covered. Some agencies had advisory groups that advised them on the proposal. At times the DHANES planning staff met with these advisory groups.

The most common reason for proposed content NOT getting onto the survey was lack of feasibility of performing the specific element in the mobile examination center. This included taking too long, not being safe to perform in a survey/trailer setting, or a poorly standardized protocol. Examination content that WAS further considered for inclusion sometimes required extensive consideration to get to a final protocol. An example is the Total Body Dual X-ray Absorptiometry component. See Reference 5.7. Laboratory and questionnaire content were evaluated by the same criteria as the examination content. Some questionnaire content was mandated by the DHHS Survey Integration that occurred in the late 1990s.

After the initial protocol was developed for the survey fielded in 1999, further announcements were sent out to solicit new content. These were sent to a large mailing list of current and past collaborators and any individual or group that expressed interest in NHANES. Additionally, calls for proposals were posted on the NHANES website and announced via the NHANES listserv. Initially continuous NHANES was planned to be one year cycles. Review and acceptance of proposals were continued nonstop. Because of this sample design and operation format, some new content began in 2000 or ended in 2001.

In 2001, a decision was made to solicit content, plan the survey, collect the data, and release it in two-year cycles. Thus, the solicitation for new proposals would occur every two years. The continuous NHANES continues to operate in these two-year cycles today. Examples of examination content added in recent years are: dermatology component (2003-2004), ophthalmologic component (2005-2008), spirometry with bronchodilator and exhaled nitric oxide (2007-2010), bone density of the hip and spine (2005-2010), inflammatory arthritis (2009-2010) and the oral glucose tolerance test (2005 -2010). Additionally for the 2003-2004 survey, content was proposed and accepted for data collection that would take place on a later date after the examination. These include a self administered food frequency questionnaire (2003-2006), the physical activity monitor (2003-2006).home allergy dust collection (2005-2006), a second dietary recall on the telephone (2002-2010), a telephone questionnaire on consumer behavior (2007-2010) and a second urine collection at home (2009-10).

Current proposal guidelines (which are much like those developed in 1996) are on the NHANES website. The major change over the years was to make the proposal a two step process where the full proposal is preceded by a letter of intent. The primary purpose of this change was to avoid having the proposer prepare a lengthy proposal for content that isn't feasible. Initially, feasibility was the primary reason for proposed content not getting onto the survey. For the 2009-2010 survey cycle, the following reasons dominated: inability of the proposer to financially support their component, or failure for a laboratory method to be fully developed.

What is considered survey core?

Given the previously described mission of DHANES, there are a number of ways you can define "core mission" for the program/division as well as "survey core" from a division perspective. Even within the longstanding NHANES survey, core could be defined in various ways. Efforts by New York City and Statistics Canada demonstrate that a "core" examination survey on a much smaller scale than the current NHANES can be defined and conducted. It is also possible to define the survey core as just the "infrastructure" and every exam or questionnaire component as "non core". The division is open to discussing these broader concepts of "survey core" with the committee.

The response below assumes that the committee's question was in reference to NHANES as currently conducted and not in reference to the broader program mission defined earlier.

The division has not specifically referred to any content of the NHANES survey as "core" but there are several components that we don't see migrating off the survey. Thus, if one uses that as an "unwritten" definition of "survey core", then the following applies.

NHANES examination core

Those components are:

- Physical examination
- Dietary Interview
- MEC interview
- Physician's examination
- Laboratory measures (blood and urine)

1. Physical examination. The physical examination component of NHANES has always included some anthropometry. Height and weight are the 2 measures within this component that will never migrate off the survey as long as obesity remains a public health concern. Blood pressure has always been part of the survey. Because the prevalence of hypertension in adults is approaching 30% and cardiovascular disease is the leading cause of death in the U.S. it is hard to imagine that this component will migrate off the survey. (Support from NHLBI in current survey)

2. Dietary Interview. The “N” in the middle of the NHANES acronym stands for “Nutrition” and the survey has always had nutrition (and diet) data since it became NHANES with the 1971-1974 survey. This data is the core of Nutrition Monitoring in the U.S for multiple Federal agencies. NHANES has now collected 5 years of dietary data in close collaboration with USDA. A decision to migrate this off the survey would impact nutrition monitoring for the entire Federal government and such a decision would involve many agencies and would only occur if USDA was no longer able to support half the data collection costs and all the back end data processing costs every year. (Major support from USDA in current survey)
3. MEC interview. Risk factors such as tobacco, alcohol and illicit drug use, and information that must be self reported on the day of the examination will require the continuation of a MEC interview. Other topics will migrate on and off the survey—such as urinary and fecal incontinence. (Support varies across survey cycles)
4. Physician’s examination. Currently we must have a physician in the trailer for our data collection contractor to get malpractice insurance. It is also inconceivable that the NCHS ERB would let the examination take place without a physician being present. The major examination component performed by the physician is the blood pressure. Their other primary duties are pre test counseling for STDs and PSA, reviewing test results from the examination requiring follow-up, making the follow-up referrals, and managing emergencies.
5. Laboratory measures (blood and urine). We do scores of tests on the urine (especially for environmental biomonitoring). It is highly unlikely that this will never migrate off the survey. The tests vary from year to year. (Virtually all tests are supported by outside sources.) We do a venipuncture and scores of tests on the blood specimen. This will never migrate off the survey. The tests and lab methods vary from year to year, however, cholesterol, basic hematology, a basis biochemistry panel, and fasting glucose are among the tests that have been a part of almost every NHANES survey. (Virtually all tests are completely supported by outside sources.)

Questionnaire core.

There is little variation from year to year in many of the NHANES questionnaire sections (except for the Medical Conditions). All of these sections below have been on the survey at least since 1988 (beginning of NHANES III) and much of the information has been collected in virtually all the HANES surveys.

- ACQ (individual)—Acculturation
- DMQ (individual)—Demographic information
- DMQ (head of household)
- DSQ (individual)—Dietary supplement use
- ECQ (individual)—Early childhood
- FSQ (individual)—Food security
- FSQ (head of household)
- HIQ (individual)—Health insurance
- HOQ (household)—Housing characteristics
- HUQ (individual)—Health care utilization

- INQ (household) —Income
- MCQ (individual)—Medical conditions
- OCQ (individual) —Occupation
- OCQ (head of household)
- PAQ (individual)—Physical activity
- PFQ (individual)—Physical functioning
- SCQ1 (head of household) —Screening*
- SCQ2 (head of household) —Family/household relationships
- SMQ (individual)—Smoking
- RXQ (individual)—Prescription drug use
- TTQ (head of household)—Tracking and tracing contacts

Many of the questions have exactly (or very similar) wording to the NHIS. Although many of the core examination components have associated questionnaire sections and are on the survey continuously they are not listed as “core questionnaire” per se.

*Note that the screener questionnaire is the questionnaire that NHANES interviewers ask at the doorstep to determine whether anyone will be sampled from that household. For each household where one or more participants are sampled we screen 5 household. This screening occurs to fulfill the oversampling requirements of the NHANES sample design. Screening costs related to over-sampling are a key aspect of the cost of the currently designed NHANES survey.

Is the core sufficient to provide as assessment of the US population?

The answer to this question depends on what one defines as an “assessment of the US population”. A small focused health examination survey will provide an assessment of the US population for selected public health issues. The “de-facto core” defined above for the current NHANES survey will provide an assessment of the US population for some public health issues. It would not provide the broad assessment of public health issues that the current NHANES survey provides (as currently funded and conducted). The current NHANES mechanism (or infrastructure) is most cost effective and scientifically useful when “completely utilized”. Again, the answer to this general question depends on the committee’s purpose in asking the question and the NHANES program staff feel this is best discussed “in person” with the committee.

What is determined by funding by outside sources?

The size and scope of NHANES is a function of both NCHS funding and funding from collaborators. For most two-year cycles of the continuous NHANES, between 30 and 40 percent of the funding comes from collaborators. Some aspects of what is determined by funding from outside sources was alluded to in the response to question #5. For the continuous survey, we have utilized a cost model to determine costs and required funding for “non-core” components of NHANES. It is not practical to go into detail here on how that cost model functions. We will be

happy to discuss general aspects of this topic with the committee when we meet. As stated previously, it is possible to conduct a much smaller “core” NHANES like survey with fewer (or no) outside funding sources. It would not look like the current NHANES, but, as stated previously, it would be a health measures survey using examination procedures, and thus a smaller “NHANES like” survey.

6) How is staff distributed across the activities of NHANES, e.g. planning, analysis?

As of October 10, 2008, in the Division there are 56 federal employees and 17 contractors, some of whom work part-time in both categories. There are currently 3 vacancies for external hires, but we are not allowed to recruit to fill them at this time. DHANES also has 5 visiting researchers at this time and 1 EIS officer.

Below is a listing of DHANES staff organized by branches. For the most part, each branch does the function identified in its title. However, analysis crosscuts the Division as some staff in each branch is involved in analysis of the data and publishing their work. To some extent, planning and operations work cuts across the branches as well.

Office of the Director

1) Cliff Johnson, MSPH
Director
MSPH, Biostatistics

2) Lewis Berman, MS
Computer Scientist
MS, Computer Science

3) Lisa Broitman, MPA
Public Health / Budget Analyst
Master of Public Administration

4) Darlene Cherry
Secretary

5) Randy Curtin, PhD
Mathematical Statistician
PhD, Biostatistics

6) Geraldine McQuillan, PhD
Senior Infectious Disease Officer
PhD, Infectious Disease Epidemiology

7) Susan Schober, PhD
Associate Director for Science
PhD, Epidemiology

8) Valerie Wallingsford
Administrative Officer

9) Te-Ching Chen, PhD
Contractor, Mathematical Statistician

10) Jody McLean, MPH
Contractor – Genetics Analyst

11) Jocelyn Kennedy-Stephenson, MS (60% time)
Contractor, Analytic Programmer

12) Michael Volynski, PhD (40% time)
Contractor, Software Computer Architect
PhD, Computer Science

13) Viktor Zhardzetski, MS (45% time)
Contractor, Software Developer
MS, Science/Mathematics

Analysis Branch

1) Rosemarie Hirsch, MD, MPH
Medical Officer (Rheumatology)
Chief, Analysis Branch
Research: arthritis and pain epidemiology; analgesic use

2) Margaret Carroll, MSPH
Health Statistician
Research: hypertension, lipids and lipoproteins, obesity, design effects and small area estimation

3) Yinong Chong, PhD (Sociology), BS (Journalism)
Epidemiologist
Research: survey participation; NHANES tutorial

4) Bruce Dye, DDS, MPH
Dental Officer
Research: pediatric and adult oral health

5) Bethene Ervin, PhD, RD

Epidemiologist (Nutrition)

Research: nutrition status in the elderly; dietary supplements

6) Cheryl Fryar, MS

Health Statistician

Research: behavioral risk factors, race/ethnic disparities; NHANES tutorial

7) Lillian Ingster, PhD

Epidemiologist

Research: cardiovascular disease epidemiology, health care utilization

8) Anne Looker, PhD, RD

Distinguished Consultant

Research: bone and mineral health; anemia and iron status; micronutrient status

9) Deanna Kruszon-Moran, MS

Health Statistician

Research: infectious disease epidemiology; immunization markers

10) Cynthia Ogden, PhD (international nutrition), MRP (regional planning)

Epidemiologist (Nutrition)

Research: childhood and adult obesity; growth charts

11) Jacqueline Wright, DrPH, MPH

Epidemiologist (Nutrition)

Research: Nutrient intake estimation and dietary assessment methodology; trends in hypertension and hypercholesterolemia

Informatics Branch

1) Jerry Del Rosso

Supervisory IT Specialist

BS, Electrical Engineering

2) Shannon Corcoran

IT Specialist

Working on BS in Information Systems/Computer Science

3) Jennifer Dostal

IT Specialist

BS, Journalism; BS, Environmental Science

4) Alexander Felberg, MS
Computer Scientist
BS, Shipbuilding (naval architect), MS, Social Science

5) Veronika Litvak, MS
Computer Scientist
MS, Management of Information Systems

6) Anh T Nguyen
IT Specialist
BS, Computer and Information Sciences

7) Tatiana Nieves, MS
Computer Scientist
MS, Pharmaceutical Science

8) Edward L. Stammerjohn, MS
Computer Scientist
MS, Industrial Engineering, BS, Engr Physics

9) Tim Tilert
Computer Scientist
BS, Mathematics

10) Jane Zhang, MS
Computer Scientist
MS, Interdisciplinary science

11) Howard Xu, MS
Contractor, SAS Programmer/Analyst
MS, Computer Science/Mathematics

12) Hua Di, MS
Contractor, SAS Programmer/Analyst
MS, Applied Economics

13) Leighton Evans
Contractor, Data Base Administrator
Business Data Processing

14) Allan Fisher, BS
Contractor, Project Manager
BS, Accounting

15) Ed Kemper, PhD
Contractor, SAS Programmer/Analyst
PhD, Astronomy

16) Xianfen Li, MS
Contractor, Statistical Programmer
MS, Statistics

17) Jian Song, MS
Contractor, SAS Programmer/Analyst
MS, Civil Engineering

Operations Branch

1) George Zipf, MS
Branch Chief
MS, Applied Statistics

2) Ana Chavez, MS
Public Health Analyst

3) Nancy Krauss, MS, RN (retiring 10/31)
Public Health Analyst
Masters in Statistics

4) Tatiana Louis, MS
Public Health Analyst

5) Vera Osidach, MS
Biomedical Engineer

6) Yechiam Osthega, PhD, RN
Nurse Consultant
Research interest: blood pressure, muscle strength, social support, Community HANES

7) Michelle Poulos, BA
Budget Analyst

8) Kathryn Porter, MD, MS
Medical Officer

9) Debra Reed-Gillette, MS
IT Specialist
MS Information Systems

10) Catherine Rodriguez
Program Support Assistant

11) Denise Schaar, BA
Public Health Analyst
BA, Child Development, BA, Psychology

12) Dave Larson, MS (10% time)
Contractor, Electrical Engineer

13) Bob Benson (50% time)
Contractor, Data Manager

Planning Branch

1) Vicki L. Burt, ScM RN
Chief, Planning Branch
MS Biostatistics
Primary research interests: cardiovascular disease, epidemiology of aging

2) Lori Borrud, DrPH
Epidemiologist (Nutrition)
Primary research interests: Body composition, bone density, bowel health, urinary incontinence, weight history

3) Debra Brody, MSPH
Epidemiologist
Primary research interests: Environmental health - with focus on lead and secondhand smoke exposure, mental health and reproductive health

4) Charles Dillon, MD, PhD
Medical Officer for Chronic Disease Studies
MD, PhD Anthropology
Primary research interests: Arthritis & Musculoskeletal Disorders; Cardiovascular Disease & Hypertension; Respiratory Disease & Allergy; Neurologic Disorders (Audiometric Surveys, Vestibular/Balance Disorders); Environmental & Occupational Health; Pharmaco-Epidemiology.

5) Natalie E. Dupree, MS
Epidemiologist
MS Biostatistics

Primary research interests: dermatology, social support & health, mind body health

6) Mark Eberhardt , PhD

Epidemiologist (Chronic Disease)

PhD in Epidemiology

Primary research interests: diabetes and renal disease epidemiology

7) Qiuping Gu, PhD

Epidemiologist

PhD Toxicology

Primary research interests: cardiovascular disease, diabetes, pharmacological treatment, and environmental health.

8) Jeffery P. Hughes, MA MPH

Epidemiologist

MA Sociology

Primary research interests: physical activity and health, epidemiology of aging

9) David A. Lacher, MD, MEd

Medical Officer (Clinical Pathology)

MEd Applied Statistics

Primary research interests: Clinical Chemistry, Informatics, Applied statistics

10) Brenda Lewis, MPH

Medical Technologist

Primary research interests: laboratory related topics

11) Margaret McDowell, PhD, MPH, RD

Health Statistician

MPH Nutrition, PhD Public and Community Health

Primary research interests: nutritional status assessment, dietary assessment methodology, dietary exposure, and anthropometry

12) Lisa Mirel, MS

Health Statistician

MS Biostatistics

Primary research interests: sample design, sample weight calculations, and analysis of complex surveys

13) Kathy L. Radimer, MPH PhD

Epidemiologist (Nutrition)

PhD Nutrition

Primary research interests: food insecurity/poverty, dietary supplement use

14) Chia-Yih Wang, Ph.D.

Senior Service Fellow

PhD Nutrition

Primary research interests: nutritional epidemiology, dietary behavior and cardiovascular disease

15) Jamie Wilger, MPH

Service Fellow

Primary research interests: dietary supplements

16) Sarah Yoon, PhD

Senior Service Fellow

PhD Clinical Epidemiology

Primary research interests: Cardiovascular disease and stroke

17) Janet Barletta, Ph.D.

Contractor

Medical Technologist

PhD Microbiology

Primary research interests: Rapid diagnostic test methods for viruses, prions using real-time PCR, immuno-PCR, and nanoparticles

18) Melissa Dimeler (20% time)

Contractor, Dietary Supplement Database

19) Cindy Zhang, MPH BMed

Contractor

Primary research interests: environmental epidemiology, children's health, epidemiology of aging

Others in the Division

Molly Lamb, PhD

EIS Officer (with us for 2 years from summer 2008)

Research: Obesity

Regan Bailey, PhD

NIH/ Office of Dietary Supplements

Research: Dietary Supplements

Ajay Yesupriya

CDC/ National Office of Public Health Genomics

Research: Genetics

Mariana Lazo

Johns Hopkins University School of Public Health

Research: Non-alcoholic fatty liver disease

Ruben Hernaez

Johns Hopkins University School of Public Health

Research: Non-alcoholic fatty liver disease

Susanne Bonekamp

Johns Hopkins Medical Institute

Research: Non-alcoholic fatty liver disease

7) Are there any documents available that discuss in more detail the goals of a longitudinal design and had any longitudinal designs been identified, discussed and evaluated at NCHS?

The idea of conducting a longitudinal survey has been re-addressed at various points in time over the last 20 years, and there is continuing interest (both internal and external to the division) in the potential of a longitudinal NHANES survey. However, funding issues have continually precluded the realization of that potential. The documents that discuss the goals of a longitudinal survey and potential designs are numerous and lengthy. We have summarized the efforts below. We will be happy to provide any of the attachments referenced.

1. NHANES III early effort

NHANES III had been marketed as a survey that would have a longitudinal follow-up before data collection began in 1988. The goal was to begin a follow-up study at the end of data collection for NHANES III (around September 1994) and to complete this before beginning the next cross-sectional survey (originally planned to begin in 1996). There was a great deal of interest from potential collaborators, particularly from several NIH Institutes. This was discussed in numerous meetings with collaborators. Division staff developed a plan, timeline, and budget estimate; created a Statement of Work; did research on what manner of laboratory component could be done with a home examination; and developed draft questions for some topics. Ultimately there was no NCHS funding for this study.

We have two documents related to this effort:

Reference 7.1: Overview of NHANES III Longitudinal Follow-up

Reference 7.2: Statement of Work to conduct a longitudinal follow-up of NHANES III.

2. NHANES III follow-up 1999-2000 effort

In 1999-2000, DHANES again explored the possibility of conducting a follow-up study of the NHANES III cohort. This did not progress very far because of lack of funding. The documents we have pertaining to this effort are:

Reference 7.3: Agenda for a May 1999 internal meeting to begin exploration of a follow-up study

Reference 7.4: Proposal for NHANES III Longitudinal Study

Reference 7.5: Memorandum to solicit proposals from potential collaborators

3. 2000 CDC Longitudinal Studies Initiative

In 2000, NCHS and DHANES led an effort to develop a CDC-wide Longitudinal Studies Initiative to provide a frame-work for obtaining CDC funding for longitudinal studies. We were particularly interested in working on this effort for potential funding for NHANES follow-up efforts.

Through a task-order contract, DHANES supervised the development of an inventory of existing longitudinal studies, commissioned two white papers on priorities for longitudinal studies (one for studies of children and another for studies of adults), and hosted a workshop to obtain input from the scientific community on these priorities.

NCHS presented a summary of the initiative including recommendations to the CDC Excellence in Science Committee but there was no further follow-up.

The major document that is available from this initiative is:

Reference 7.6: The CDC Longitudinal Studies Initiative Summary Report

The inventory of longitudinal studies and the two white papers can also be provided. The white papers are: 1) CDC Longitudinal Studies Initiative (Adult Cohorts) by R. Wallace, S. Watanabe-Galloway, and A.R. Herzog and 2) Longitudinal studies among children: implications for future research by S.R. Tortolero and G.S. Parcel.

4. NHANES 1999-2004

As part of the NHANES 1999-2004 data collection contract there was an option to do a follow-up telephone interview with NHANES participants 60 and older. The idea was to have a follow-up related to health and disability transitions. That option was never exercised.

8) Has NCHS proposed any NHANES budget initiatives to CDC over the last several years? If so, what was the result of NCHS efforts? Were there any initiatives?

This question will be answered by the NCHS Office of the Director.