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Department of Health and Human Services

**Board of Scientific Counselors
National Center for Health Statistics
Centers for Disease Control and Prevention
May 5, 2020**

Meeting Summary

The Board of Scientific Counselors (BSC) convened via Zoom on May 5, 2020. The virtual meeting was open to the public (via Zoom).

Board Members Present

Linette T. Scott, M.D., M.P.H., Chair, BSC
Kennon R. Copeland, Ph.D.
Prashila Dullabh, M.D.
Darrell J. Gaskin, Ph.D.
Robert M. Hauser, Ph.D.
Mark Hayward, Ph.D.
Scott H. Holan, Ph.D.
Helen G. Levy, Ph.D.
R. John Lumpkin, M.D., M.P.H.
Kristen M. Olson, Ph.D.
Andy Peytchev, Ph.D.
Ninez A. Ponce, M.P.P., Ph.D.
Gretchen Van Wye, Ph.D., M.A.

CDC/NCHS Participants

Brian Moyer, Ph.D., Director, National Center for Health Statistics (NCHS)
Jennifer Madans, Ph.D., Deputy Director, NCHS
Sayeedha Uddin, M.D., M.P.H., Designated Federal Officer, NCHS
Chesley Richards, M.D., M.P.H., F.A.C.P., Deputy Director for Public Health Science and Surveillance,
CDC
Geoffrey Jackson
Gwen Mustaf
Paul Sutton

Other Attendees

Joyce Abma	Adena Galinsky	Jennifer Parker
Alicia Adams	Debra Gilliam	Ryne Paulose
Viviana Aguila	Renee Gindi	Sue Pedrazzani
Naman Ahluwalia	Cordel Golden	Kellina Phan
Farida Ahmad	Jessica Graber	Robert Phillips
Akintude Akinseye	Brian Gugerty	Steve Pierson
Johanna Alfier	Leda Gurley	John Pleis
Josephine Alford	Craig Hales	Paul Pulliam

Bob Anderson	Brady Hamilton	Cynthia Reuben
Elizabeth Arias	Nancy Han	Vincent Rome
Ima Arispe	Yulei He	Dorothy Roper
Jill Ashman	Holley Hedegaard	Lauren Rossen
Rihem Badwe	Kevin Heslin	Charles Rothwell
Brenda Baker	Rebecca Hines	Matt Rowe
Patricia Barnes	Jacquie Hogan	Jennifer Sayers
Vladislav Beresovsky	Isabelle Horon	Susan Schappert
Greg Binzer	John Hough	Margo Schwab
Amy Blum	Donna Hoyert	Steven Schwartz
Stephen Blumberg	Ed Hunter	Salah Shaikh
Blair Bowers	Chrissy Jarman	Iris Shimizu
Amy Branum	Olga Joos	Priyanka Singh
Kate Brett	Jessly Joy	Margaret Skurka
Jim Brittain	Diba Khan	Sandra Smith
Lisa Broitman	Richard Klein	Stephen Smith
Sherry Brown-Scoggins	Ji-Eun Kim	Merianne Spencer
Aileen Buckler	Kenneth Kochanek	Marietta Squire
Verita Buie	Ellen Kramarow	Suresh Srinivasan
Christine Caffrey	Denys Lau	Tammy Stewart-Prather
Amy Cha	Florence Lee	Renee Storandt
Anjani Chandra	Jessica Lendon	Yu Sun
Karishma Chari	Sarah Lessem	Makram Talih
Te-Ching Chen	Linda Lin	Chally Tate
James Cimino	Donald Malec	Betzaida Tejada-Vera
Jay Clark	Crescent Martin	Ana Terry
Kimberly Cook	Meredith Massey	Eric Tolliver
Christine Cox	Juliana McAllister	Anjel Vahratian
Nichole Cummings	Taylor McEwen	Lisa Wagner
Barnali Das	Tabatha McNeil	Chia-yih Wang
Carol DeFrances	Kaye Meier	Brian Ward
Lorraine Doo	Bibimasoumeh Mir Mousavi	Margaret Warner
Anne Driscoll	Lisa Mirel	Julie Weeks
Evelyn Dunn	Leyla Mohadjer	Donielle White
Natalie Dupree	Mary Moien	Stephania Willson
Nazik Elgaddal	Kelly Myrick	Bryan Williams
Danielle Ely	Tony Nguyen	Stephanie Willson
Tala Fakhouri	Zakia Nelson	Kimberly Williamson
Lee Anne Flagg	Kathleen O'Connor	Jianmin Xu
Sheila Franco	Damon Ogburn	Carla Zelaya
Alicia Frasier	Cynita Ogden	Call-in Participants (<i>n</i> =28)
Hannah Fuchs	Ada Okorie	
Tina Baker	Greg Richards	Dana Gleit
(Captioner)	(Meeting Host, Rose Li and Associates)	(Minutes, Rose Li and Associates)

List of Abbreviations

AMA	American Medical Association
BLS	Bureau of Labor Statistics
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CHIS	California Health Interview Survey
COD	cause of death
DHCS	Division of Health Care Statistics
DHIS	Division of Health Interview Statistics
DVS	Division of Vital Statistics
ICD-10	International Classification of Diseases, 10th Revision
NAMCS	National Ambulatory Medical Care Survey
NCHS	National Center for Health Statistics
NHANES	National Health and Nutrition Examination Survey
NHIS	National Health Interview Survey
PCORTF	Patient-Centered Outcomes Research Trust Fund
RANDS	Research and Development Survey
RDC	Research Data Center
SUD	substance use disorder
TCAs	tricyclic antidepressants

Action Steps

- The BSC voted unanimously to endorse the recommendations regarding additions to the Validation Study Abstraction form that were provided by the Patient-Centered Outcomes Research Trust Fund (PCORTF) Drug Workgroup.
- Dr. Moyer welcomes any suggestions from BSC members about how NCHS could better respond to COVID-19.
- Dr. Moyer would also value input from the BSC members regarding the long-term vision for NCHS.
- Future BSC meeting dates for the remainder of 2020: September 17-18.

Tuesday, May 5, 2020

Presenters

Brian Moyer, Ph.D., Director, NCHS
Jennifer H. Madans, Ph.D., Acting Deputy Director, NCHS
Paul Sutton, Ph.D., Deputy Director, Division of Vital Statistics (DVS)
Geoffrey Jackson, M.S., Hospital Care Team Lead, Division of Health Care Statistics (DHCS)
Gretchen Van Wye, Ph.D., M.A., Chair, PCORTF Drug Workgroup
John Lumpkin, M.D., M.P.H., Chair, National Hospital Ambulatory Medical Care Survey (NAMCS)
Workgroup

Welcome, Introductions, and Call to Order

Linette T. Scott, M.D., M.P.H., Chair, BSC
Sayeedha Uddin, M.D., M.P.H., Designated Federal Officer, NCHS, BSC

Dr. Scott called the meeting to order. She asked BSC members to introduce themselves and state any conflicts of interest. No one reported a conflict of interest.

Dr. Uddin introduced the NCHS team including Dr. Moyer, who became the new Director of NCHS approximately one month ago.

NCHS Update

Brian Moyer, Ph.D., Director, NCHS
Jennifer H. Madans, Ph.D., Acting Director, NCHS

Dr. Moyer introduced himself as an economist by training. He worked for 27 years at the Bureau of Economic Analysis—as director or deputy director for the past 10 years.

Dr. Moyer thanked Dr. Madans in particular for her excellent leadership as Acting Director for NCHS since Mr. Rothwell retired more than one year ago. He praised her outstanding work to advance the NCHS mission.

Although he does not yet have a full long-term vision for NCHS, Dr. Moyer highlighted some areas of opportunity related to data modernization. First, he places a high priority on harnessing new data and techniques. Second, he wants to focus on expanding the capacity and scope of statistical analysis (e.g., better packaging of the data for policy purposes, analyses that target policy needs). Third, he would like to improve the data connections across the entire statistical system to facilitate sharing and linkage of NCHS data with broader datasets at CDC and with other datasets within the statistical system.

Dr. Moyer emphasized that NCHS’s workforce is its greatest asset. He complimented the exceptionally high quality of the current staff. For the future, he hopes to improve coordination and collaboration within the Center. Many NCHS staff are closely associated with particular programs, but he hopes to empower staff to share their skills and strengths across the entire organization.

The COVID-19 Response

NCHS has responded to the pandemic in three ways. First, NCHS has accelerated the availability of its statistics. For example, DVS has been frequently updating provisional death counts. Last week, DVS also released excess death counts. Second, the center is expanding existing surveys to include new COVID-related questions. Third, NCHS and seven other statistical agencies have collaborated with the Census

Bureau to field the Household Pulse Survey. Release of results from this web panel survey could begin during the week of May 11.

Administrative & Budget Update

The FY2020 minibus¹ budget (\$160M) for NCHS has remained at the same level since FY2016. As part of the Public Health Data Modernization Initiative, the FY2020 appropriations allocated an additional \$50M to CDC. The congressional report highlighted NCHS in particular as a key recipient and implementer of these data modernization funds. To date, NCHS has received \$3.4M from that funding source. In the FY2021 budget, the amount requested for this initiative is lower (\$30M) and there is no explicit mention of NCHS.

The FY2021 President's proposed budget is \$5.4M lower than the FY2020 minibus. Nonetheless, Dr. Moyer noted that NCHS fared better than many other centers within CDC. In addition, this budget was proposed prior to the extensive spread of COVID-19 in the United States and could change before finalization. As in prior years, the NCHS total budget will also include about \$14M that is transferred from CDC to NCHS; the only difference is that the transfer will be more formally recognized.

CDC will also receive COVID-19 Supplemental Funding from three sources. First, the Coronavirus Preparedness and Response Supplemental Appropriations Act (passed on March 6) allocated \$2.2B to CDC. To date, NCHS has received \$2M of those funds to support work on vital statistics. Those funds will be available through FY2022. Second, the Coronavirus Aid, Relief, and Economic Security Act (passed on March 27) allocated \$4.3B to CDC. Although NCHS has not yet received any of those funds, \$500M was targeted for data modernization, and CDC is working to determine how the funds will be allocated. Those funds will be available through FY2024. Third, the Paycheck Protection Program and Health Care Enhancement Act (passed April 24) allocated \$1B to CDC, and the funds are available until expended. This funding requires CDC to provide monthly reports on COVID-19 cases, hospitalizations, and deaths, including tabulations by demographic subgroups (i.e., sex, age, race/ethnicity, geographic region).

NCHS Publications

Recently, NCHS released reports on the increase in suicide mortality, hypertension prevalence, marriage rates, and electronic cigarette use. Upcoming reports will cover sexual activity and contraceptive use as well as the provisional birth data for 2019.

Dr. Moyer concluded by recognizing the departing BSC members: Dr. Ninez Ponce, Dr. Mark Hayward, Dr. Prashila Dullabh, Dr. Darrell Gaskin, and Mr. Robert Santos. Dr. Moyer thanked all of them for their excellent advice and valuable service.

COVID-19 and NCHS Survey Programs

Dr. Madans reviewed how the survey programs have been affected by and responded to COVID-19.

National Health and Nutrition Examination Survey (NHANES)

Data collection for NHANES ceased on March 16 out of concern for both participants and staff. The NHANES Mobile Examination Centers are currently parked in Maryland. Work continues on data quality control, editing, and release of earlier years' data and data collected in 2019 through the March 16. One of the MEC laboratory vans has been repurposed for COVID-19 testing in DC. NCHS is also discussing some proposals to use NHANES blood samples for antibody testing of COVID-19.

¹ Includes funding for administrative and business services through the CDC Working Capital Fund.

A key question is when NHANES can resume data collection and what will it look like it. Dr. Madans explained that the Division of Health and Nutrition Examination Surveys can require about six months of lead time to start data collection in any area depending on the length of time out of the field. The longer the survey remains on hiatus, the more difficult it will be to bring staff back and implement the necessary retraining. She warned that NHANES may not be able to return to the field until 2021. In addition, she reminded the BSC that this was the round in which each year of NHANES data collection does not comprise an independent representative sample. That is, the data collected during 2019 nor the first few months of 2020 are not nationally representative. Thus, NCHS must consider whether to resume the data collection to complete the 2019-2020 sample. This decision will depend on how long the survey is out of the field.

Health Care Surveys

The Health Care Surveys were just finishing 2019 data collection and had not yet begun 2020 collection when the pandemic affected field operations. Some of the health care surveys had planned to begin fieldwork in May 2020, but are currently on hold. NCHS plans to begin induction interviews by phone as soon as possible and to add COVID-19-related questions to all the provider surveys. These questions would cover shortages of personal protective equipment and use of telemedicine. Ultimately, NCHS hopes to incorporate COVID-specific information into the standard data already collected to gain a more in-depth understanding of the pandemic's impact on the health care system.

National Health Interview Survey (NHIS)

Data collection for NHIS is ongoing, but in-person collection was suspended on March 19. All incomplete cases from March were transitioned to phone contact only. Compared with February, the response rate was only 2% lower in March. Unfortunately, the Division of Health Interview Statistics (DHIS) did not have phone numbers for most of the addresses selected for April, although they have obtained good response rates for the households they were able to contact and have been successful in obtaining phone numbers for a large number of sampled addresses. NCHS is carefully evaluating the potential bias resulting from selective ability to contact households. DHIS is also considering whether to substitute the 2019 sample (for whom they do have phone numbers) to finish the 2020 sample.

In July, NHIS will begin evaluating new questions regarding SARS-COV-2 testing; COVID-19-related hospitalizations; problems accessing non-COVID-related health care; immunosuppression; telemedicine; and the effect of COVID on social support. DHIS has also collaborated with the Census Bureau to add questions to the Pulse Survey (e.g., anxiety and depression, health insurance coverage, non-COVID-related health care).

Research and Methodology: COVID-19 Response

The Research Data Centers (RDCs) are closed to researchers. NCHS has offered assistance from its own staff to help conduct analyses on behalf of external users, particularly those with high-priority projects. Cognitive interviewing by the Collaborating Center for Questionnaire Design and Evaluation Research has ceased, but the center is exploring possible means for conducting virtual interviews. The existing Research and Development Survey (RANDS) is a series of data collections from commercial-recruited probability panels and is largely web-based. NCHS is considering whether to repurpose RANDS to collect data related to COVID-19. NCHS staff would calibrate those data with corresponding questions in the NHIS.

Dr. Madans closed by thanking everyone and expressing how much she enjoys working with the BSC. She looks forward to continuing that relationship.

Discussion/Reaction by the Board

The issues highlighted during the discussion included strategies for reducing provider burden and exploring alternative survey modes.

One BSC member noted that providers are overburdened and wondered whether NCHS is coordinating with other organization that may be planning provider surveys (e.g., American Medical Association [AMA]). Dr. Madans replied that NCHS has been concerned about respondent burden, particularly for hospitals and long-term care facilities. NCHS has been monitoring other provider surveys; most of those other surveys appear to have paused. She agreed that it would be helpful to contact the AMA and other professional organizations to understand their plans. NCHS plans to start slowly with induction interviews only. If, after a few weeks, it finds the response to be poor, data collection will be suspended. Of key interest is the pandemic's effect on the use of telemedicine, which can be obtained via NHIS and RANDS (at least from the patient's point of view). NCHS is also interested in whether preventive care is continuing, but recognizes that it may be necessary to do that investigation retrospectively.

Regarding alternative survey modes, a board member noted that the California Health Interview Survey (CHIS) moved from computer-assisted telephone interview to a web-based survey, and thus has been able to continue data collection. In fact, CHIS has seen a slight increase in its response rate. CHIS received approval to add some COVID-related questions, which it will share with NCHS to facilitate harmonization. Dr. Madans explained that, in the past, NCHS has experienced difficulties with obtaining adequate response to web-based surveys, but she acknowledged that the situation may be changing. Another BSC member endorsed the idea of considering alternative survey modes because the situation will likely persist for a long time. Dr. Madans emphasized that NCHS's priorities are to determine activities for the next several months and to prepare for the future so that it has more options.

Coronavirus Disease (COVID-19) Reporting Guidance and Provisional Death Data

Paul Sutton, Ph.D., Deputy Director, Division of Vital Statistics

Dr. Sutton reviewed NCHS's efforts during recent months to improve timeliness of death reporting. He noted that the magnitude of the work responding to COVID-19 is far greater than anything NCHS has previously experienced.

COVID-19 Response Timeline

Dr. Sutton provided a timeline for the NCHS response to COVID-19:

- February 26: DVS decided to develop certification guidance for physicians reporting COVID-19 deaths.
- March 4: DVS released preliminary guidance for certifying COVID-19 deaths.
- March 17-20: NCHS updated the cause of death (COD) coding system and created a new ICD-10 code for COVID-19.
- March 25: NCHS launched a webpage (<https://www.cdc.gov/nchs/nvss/covid-19.htm>) for resources related to COVID-19 death data.
- March 27: DVS prioritized manual COD coding for jurisdictions with a high volume of COVID-19 deaths.
- April 2: NCHS released final guidance for certifying COVID-19 deaths.
- April 3: NCHS released the first provisional COVID-19 death counts, which are updated every weekday.

- April 16: Several DVS staff (i.e., Robert Anderson, Anne Flagg, Frieda Aman) made presentations during the Clinician Outreach and Communication Activity webinar, which reached nearly 17,000 participants.
- April 29: DVS released a visualization for excess deaths associated with COVID-19.
- May 1: NCHS redesigned the webpages that present provisional COVID-19 deaths.

Guide for Certifying COVID-19 Deaths

Dr. Sutton highlighted the key points of this guide (www.cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf):

- If COVID-19 played any role in the death, it should be mentioned on the death certificate.
- DVS will allow use of the abbreviation “COVID-19” on the death certificate.
- All contributing and pre-existing conditions that complicated the death should be included in Part 2 (contributing causes) of the death certificate.
- Certifiers are allowed to report COVID-19 on the death certificate as “probable” or “presumed,” using their best clinical judgement. Ideally, deaths would be attributed to COVID-19 based on testing, but DVS recognizes that testing has not always been possible during this pandemic.

New ICD-10 Code for COVID-19 (U07.1)

DVS is using a new ICD-10 code (U07.1) for COVID-19. Although the World Health Organization introduced a second code (U07.2) for deaths in which laboratory confirmation was inconclusive or not available, NCHS does not plan to implement U07.2 because U.S. death certificates do not routinely capture information about testing. Whether COVID-19 is coded as the underlying COD depends on which conditions are reported and where they are reported on the death certificate. Nonetheless, given the rules regarding coding, NCHS expects that COVID-19 will be coded as the underlying COD in the vast majority of deaths where COVID-19 is mentioned on the death certificate. To date, that appears to be the case in greater than 90% of COVID-associated deaths.

Process for Coding COVID-19 Deaths

DVS made several modifications to the coding system, which was not designed to code COVID-19 or to accept the U07.01 code. DVS also established and documented new coding rules. Initially, all COVID-19 records were manually coded, which vastly increased the demand on staff. Even before receipt of large numbers of COVID-19 records, DVS diverted all possible staff to support manual coding. Consequently, DVS reduced the backlog for manual coding to 3 days. Since then, DVS has maintained the backlog at 3-5 days, but the strain is increasing rapidly. The systems have been automated to code some (~27%) COVID-19 deaths, but DVS is working diligently to increase that capability. DVS also realized that the coding rules required adjustment to accept “COVID” as shorthand for “COVID-19,” because the former is widely used.

Provisional COVID-19 Death Counts

Dr. Sutton showed a table of COVID-19 provisional death counts as of May 1, but noted that the numbers had already been updated twice since then. Early on, NCHS and CDC officials discussed possible overlap among deaths from COVID-19, pneumonia, and influenza. Thus, the provisional death counts include not only a category for COVID-19 deaths, but also categories for deaths resulting from pneumonia and influenza, with a summary category for all deaths resulting from any of these three causes. As of May 1, the number of COVID-19 deaths was 37,308, whereas the total number of deaths resulting from COVID-19/pneumonia/influenza was 90,165. These counts lag behind those reported in the media and other sources (e.g., Johns Hopkins University) by up to two weeks, because it takes more time to complete the death certificates and to code COVID-19 deaths. To help educate users, NCHS has posted “Understanding the Numbers: Provisional Death Counts and COVID-19”

(<https://www.cdc.gov/nchs/data/nvss/coronavirus/Understanding-COVID-19-Provisional-Death-Counts.pdf>). This one-page factsheet explains differences between provisional and final deaths counts; emphasizes that these counts should not be compared across jurisdictions because the lag in reporting deaths varies across states; and notes that other reporting systems use different definitions and methods for counting these deaths.

The provisional death counts from COVID-19, pneumonia, influenza, and other COD (with and without COVID-19) are tabulated by sex, age, and race/ethnicity. These data are provided not only at the national level, but also by state/jurisdiction. One table includes county-level data for larger counties. However, all sub-national counts below 10 are suppressed to protect confidentiality. Dr. Sutton presented a graph showing the percentage of all deaths resulting from COVID-19/pneumonia/influenza alongside the seasonal baseline. The sharp increase between the 10th and 15th week of 2020 is far greater than the increase observed during the winter of 2017-18, which was the worst influenza season in a decade.

Furthermore, DVS has been reporting the racial/ethnic distribution of COVID-19 deaths compared with the population (unweighted as well as weighted to account for the fact that the COVID-19 pandemic is not evenly distributed across the population). For example, non-Hispanic Blacks/African Americans account for 25% of the COVID-19 deaths in New York City, although they represent only 22% of the (unweighted) population.

The provisional death counts are publicly available at <https://www.cdc.gov/nchs/nvss/vsrr/covid19/> and are simultaneously posted to data.cdc.gov, where the data can be exported in a variety of formats. The data portal also has an application programming interface for automated access.

DVS also reports the percentage of expected deaths (i.e., an indicator of excess mortality). By the week ending on April 4, the percent of expected deaths was already 115%. Lauren Rossen led this effort to model excess mortality associated with COVID-19. Dr. Sutton presented some examples of the visualization that shows predicted weekly deaths from all causes including and excluding COVID-19 alongside the threshold for excess deaths. This visualization is available at the national level and by jurisdiction (i.e., states, New York City, DC) at https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm.

Discussion/Reaction by the Board

Most of the discussion focused on the ability of the vital statistics infrastructure to deal with these challenges and the definitions of racial/ethnic groups as well as support for the decision to adjust the coding rules.

One BSC member asked which states lagged the most in reporting and whether the ability of the vital statistics infrastructure to handle the challenge varies widely by state. Dr. Sutton replied that most vital statistics offices have proven quite resilient, although some jurisdictions experienced initial difficulties with the transition to remote work and could not access all needed systems. Most of those issues have been resolved. Large jurisdictions have generally maintained or even increased the timeliness of death reporting. Reporting has slowed somewhat in a few jurisdictions. The jurisdictions that have been slow in the past continue to be slow. All but four states have electronic death registration, which has facilitated timely reporting.

Another board member asked why Native Hawaiians and Pacific Islanders were not shown on the race/ethnic-specific tables. Dr. Sutton explained that they are included in the non-Hispanic Asian group; these are the standard racial/ethnic categories used by NCHS. He noted that more detailed racial/ethnic

categories will be provided in the micro data files, which are not yet available. DVS may consider whether to further disaggregate that subgroup in the presented tabulations, providing that the cell sizes are sufficient.

Finally, a Board member expressed support for the decision to adjust the classification criteria to include mentions of the acronym “COVID” (in place of “COVID-19”). That change will reduce the degree of undercounting. It will also be more consistent with the numbers that New York City is reporting, which includes both probable and confirmed COVID deaths.

Workgroup Updates

Dr. Uddin introduced the BSC workgroups, a means by which the Board can examine specific issues in more depth. Over the past two years, NCHS has convened four workgroups (i.e., Patient Centered Outcomes Research Trust Fund (PCORTF) Drug Workgroup, National Health Interview Survey (NHIS) Early Release Key Indicators Workgroup, Non-Response Bias Workgroup, National Ambulatory Medical Care Survey (NAMCS) Workgroup). One more workgroup is currently in the planning stage (Population Health Survey Methodology and Data Presentation Workgroup).

Patient Centered Outcomes Research Trust Fund (PCORTF) Projects Update

Geoffrey Jackson, M.S., Hospital Care Team Lead, Division of Health Care Statistics
Gretchen Van Wye, Ph.D., M.A., Chair, PCORTF Drug Workgroup

Dr. Jackson briefly reviewed the two PCORTF projects. The FY18 project aims to enhance identification of opioid-involved health encounters using linked hospital care and mortality data. The goal of the FY19 project is to identify co-occurring disorders among opioid users using the same data. The algorithms are being developed concurrently for both of these projects. The main focus for today’s presentation is the study to validate those algorithms, which is planned for late 2020.

The validation study will use a sample of encounters identified by the algorithm. For the selected cases, the medical records will be manually abstracted using data submitted by nine participating hospitals. The medical records will be reviewed to determine whether the case has been correctly identified as an opioid-related hospital visit. Those results will be used to identify the best-performing versions of both algorithms. DHCS has developed a standardized abstraction form to compile the information and record the evidence’s location within the medical records (e.g., laboratory results, medication list, history of present illness). On January 15, 2020, a special BSC workgroup convened to review the abstraction form.

Dr. Van Wye summarized the recommendations from that workgroup.

- 1) The hospital setting should be added to the encounter identification section.
- 2) The form should distinguish between past versus present use of opioids.
- 3) The fentanyl category should include fentanyl analogs.
- 4) The medication list should be included as a potential location for evidence of substance use.
- 5) The form should add a question confirming whether any testing for substances was performed.
- 6) Steroids and solvent/other inhalants should be added to the substance use disorder (SUD) list, while tricyclic antidepressants (TCAs) can be removed.
- 7) The form should allow the interviewer to include additional notes.

On April 14, 2020, DHCS staff presented the two algorithms and described the available research files during a virtual session of the 2020 Rx Drug Abuse and Heroin Summit.

The RDC release of the 2016 linked file has been delayed because staff cannot access confidential data while teleworking. The subject matter expert in natural language processing has been going into the office about once a week to move that project forward.

Discussion/Reaction by the Board

A BSC member asked why TCAs were removed from the SUD list on the abstraction form. Dr. Williams explained that although TCAs were originally on the list as a medication for abuse, TCAs are such an old class of antidepressant that cases of abuse are likely to be rare. Among the 2,000 hospital encounters that DHCS clinically annotated, there were very few cases in which a TCA was prescribed, and none of those cases involved abuse of a TCA. Therefore, the workgroup consensus was that TCAs can be removed from the list.

Actions

Dr. Scott called for a vote regarding whether the BSC supports advancing the findings provided by the workgroup as recommendations from the BSC.

The vote was unanimous in support.

National Ambulatory Medical Care Survey Workgroup

John Lumpkin, M.D., M.P.H., Chair, NAMCS Workgroup

During its January meeting, the BSC authorized the formation of a NAMCS workgroup. This group included two BSC members (Drs. Lumpkin and Copeland) as well as Dr. Caleb Alexander (Johns Hopkins School of Public Health), Dr. Rajender Aparasu (College of Pharmacy at the University of Houston), and Dr. Bob Phillips (American Board of Family Medicine).

To date, the workgroup has had two planning calls. On May 20, federal and non-federal stakeholders will convene virtually to discuss two topics. First, the group will determine the gap between the ambulatory health care data that are needed and the data currently available. Second, the group will identify the changes to NAMCS needed to address those information gaps. The results from the workgroup will be presented at the September 2020 BSC meeting.

Discussion/Reaction by the Board

There was no discussion.

BSC Wrap-up

Linette T. Scott, M.D., M.P.H.
Brian Moyer, Ph.D.

Dr. Scott thanked everyone, including those whose terms on the BSC are ending.

Dr. Moyer also thanked all the BSC members and welcomed any suggestions about NCHS's response to COVID-19. As he considers the long-run vision for NCHS, he would also value input from the BSC members based on their experiences working with NCHS.

Dr. Madans had promised the Board to provide an update on the maternal mortality data release and the communication's plan that was developed to accompany the release as the Board has provided very helpful comments during earlier briefings. As the time constraints on the agenda did not allow for a more formal briefing, she gave a short summary of the release. The final 2018 mortality data with

accompanying reports including three on maternal mortality were released on 1/30/2020. More than 1,000 participants attended the multiple NCHS briefings on the release, and more than 750 attended the webinar that focused on maternal mortality. The dedicated maternal mortality website drew 4,000 visitors on the release date. There was also a significant increase in social media traffic. The maternal mortality visual abstracts provided by NCHS have been widely used.

Public Comment

There was no public comment.

The meeting was adjourned at 1:10 pm.

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

_____/s/
Linette T. Scott, M.D., M.P.H.
Chair, BSC

_____/9/2/2020
DATE