Department of Health and Human Services

Board of Scientific Counselors

February 9-10, 2012

NCHS Auditorium
3311 Toledo Road
Hyattsville, MD 20782

Meeting Minutes

The Board of Scientific Counselors convened on February 9-10, 2012 at the National Center for Health Statistics in Hyattsville, MD. The meeting was open to the public.

Committee Members
Llewellyn Cornelius, Ph.D., Chair BSC
José Escarce, M.D., Ph.D.
Hermann Habermann, Ph.D.
Kathleen Mullan Harris, Ph.D.
Carol J. Hogue, Ph.D., M.P.H.
Holly Hedegaard, M.D.
Christine L. Himes, Ph.D.
Stanley Presser, Ph.D.
Elizabeth (Lou) Saadi, Ph.D.
Margo Schwab for Katherine K. Wallman
Katherine K. Wallman (by phone 2-10-2012)
David Takeuchi, Ph.D.
Duncan Thomas, Ph.D.

Absent
Patricia Buffler, Ph.D., M.P.H.
Raynard Kington, M.D., Ph.D.
Alan M. Zaslavsky, Ph.D.

EXECUTIVE SUMMARY

February 9-10, 2012

ACTIONS

- The BSC was asked to provide advice to NCHS about the issues surrounding informing survey participants of their genetic results; consent form revisions; and psychological distress of re-contacted respondents by May 2012. The BSC should consider the structure of a related “conference” (gathering of experts); and determine what subgroup will work on activities related to the above three issues between February and May 2012.

- Dr. Cain will refine a draft letter about re-contacting respondents, changing the current consent form to report genetic results and meeting dire duty to warn criteria within the NHANES DNA Program. Outreach and modest pilot testing will also be considered. The letter will be sent to BSC members for commentary.

- NCHS would like BSC's advice on how to work with indicator contributors in a way that ensures high quality.

- Dr. Sondik will promote the use of the Health Indicators Warehouse as a dissemination tool at the next IOM meeting.

- All BSC members will receive a copy of *Statistical Programs of the United States Government*.

Thursday, February 9, 2012

Welcome and Call to Order

Lee Cornelius, Ph.D., Chair, BSC and Edward Sondik, Ph.D., Director, NCHS

NCHS Update **Edward Sondik, Ph.D.**

The 2012 budget was described. Data timeliness is improving. In the policy arena, the focus remains on health reform and on a new initiative called *Million Hearts*, whose goal is to reduce the number of heart attacks and strokes by a million over the next five years. NCHS is working to provide new data collection standards for race, ethnicity, sex, primary language and disability status (Section 4302 of the ACA legislation) and to test lesbian, gay and bisexual (LGB) data collection within NHIS. Data systems content is expanding, for example, in NHANES, testing of sodium levels, children's fitness and mental health, infant mortality and longevity is occurring. The challenge of ICD-10-CM implementation is another focal point as the deadline for the shift from ICD-9-CM approaches. Redesigning surveys, especially for HIS and NHANES, will improve data access. Dissemination is important.

Program highlights and staff changes were described. Specific examples of improved timeliness of data release and reports were cited. The National Conference on Health Statistics will take place from August 6-8, 2012 in Washington D.C.

Division of Vital Statistics Update: National Death Index

Charles Rothwell, M.S., Director, DVS

The purpose, goal and history of the Social Security Administration (SSA) Death Master File (DMF) were outlined. The DMF was created to help Social Security reduce fraud and abuse of federally-funded benefits. In November 2011, the SSA withdrew the state death records from the public file due to concerns about the quality and accuracy of the data in the file. This action meant a reduction of a million state records annually and of 4.2 million records within the public historical file of 89 million records, which challenges researchers who no longer have access to a complete file of all deaths. On the other hand, SSA public DMF advantages include the capacity to access data faster and less expensively.

The National Death Index (NDI) is a database that records all deaths in the U.S. from 1979 forward with names, social security numbers and other personal identifying information. This provides health researchers with passive, long-term follow-up for participants in other NCHS surveys. NDI's history was presented. Initially funded by NIH, it now uses a fee structure that is self-supporting. NDI's advantages and disadvantages were outlined. A systems change could go into effect within a year that would help users obtain needed information more quickly.

Discussion A sum of $500,000 has been requested from NIH to help with a proposed systems change to disseminate fact of death information more quickly. With funding, 2011 information will be available by August 2012, if states meet their timeliness requirements. Gathering timely cause of death information is more challenging. Fact of death is usually collected from funeral directors while cause of death comes from certified physicians. Electronic records are generated through a state-run system that can be passed from funeral directors to physicians to states. This process is a "harder sell" to physicians, who must also contend with their own medical automation systems.

It was noted that national regulations on vital registration may appear for the first time. A major issue to consider on death certificate reporting has to do with race and ethnicity. The current bifurcated system contains inconsistent death record information. The NCHS Office of Analysis and Epidemiology links the NDI with Divisions' surveys. Discussion ensued about time requirements for underlying cause of death. A question was raised about the challenges of accurate and timely record keeping for pending deaths. National Association for Public Health Statistics and Information Systems (NAPHSIS), which works on this problem with NDI, maintains that further regulation is not the answer. The Electronic Verification of Vital Events (EVVE) system was described as a potential model to make death information more accessible. In response to a question about how to make it easier for researchers to obtain needed information, it was suggested that the Division work more closely with researchers from the beginning of the proposal process.

NHANES Update **Lisa Broitman, M.P.A., Deputy Director, NHANES**

NHANES release of data files for 2009-2010 and 2011-2014 samples were compared. The current status of data oversamples (2011-2014) was delineated, which included an Asian oversample for the first time. Challenges with the Asian sample were identified. Outreach was described as were endorsement letters from various Asian organizations. NHANES key response rates from more than a decade were presented and analyzed.

The NHANES National Youth Fitness Survey (NNYFS) was described as were planning challenges for the Children's Feasibility Study and NNYFS. The program will continue through 2012 although future funding is uncertain. Proposed NHANES content changes for 2013-14 were delineated. Letters of intent have been solicited with established deadlines and input from collaborators has been sought via the NHANES website and newsletter. All questions on NHANES and NHIS questionnaires will focus on comparability. New potential exam content was outlined. Questionnaire changes involve instituting some HHS data collection standards related to race, ethnicity, gender and language; awareness of hepatitis infection; and a wide range of additional issues. Recommended laboratory changes were presented along with evaluation criteria and pilot testing. Additional activities include a birth certificate linkage study; more linkage between state food assistance programs and economic data; trans-fat lab work and analyses; multiple sodium-related efforts; and genetics.

Discussion

NOTE: A field trip to visit the trailers may be scheduled around the time of the September 2012 meeting.

City selection for the Asian oversample was described as was the Birth Certificate Linkage Study.

NHANES DNA Update and BSC Working Group

Rosemarie Hirsch, M.D., M.P.H., Dep. Director, NHANES; and Lee Cornelius, Ph.D.

Presentation objectives were recapitulated. The 2009 – 2010 genetic consent form was reviewed as was a summary of the NHANES genetic consent parameters. Technological advances present an increased potential to incidentally identify clinically relevant findings, which, in turn, have led to changes in medical ethics guidance about whether or not to report results of genetic tests or those done in bio-bank specimens. Non-disclosure is no longer seen as appropriate. At a May 2011 workshop, a panel of experts addressed critical questions related to these issues. A key question is how to determine and operationalize criteria for clinically relevant genetic findings with a dire duty to warn threshold. One option is binning by loci or binning the genome, which establishes three separate categories. Only Bin 1 variants would be considered for reporting. The Evolution of Genomic Applications in Practice and Prevention (EGAPP) was identified as a possible group for doing the initial binning of the genome. A proposed working group would determine with genetic variants rose to the level of dire duty to warn. To disclose this change in procedures, a one-time re-contact would inform prior participants of reporting back consent changes and offer an opt-in or opt-out option for future contact.

A NHANES Genetic Program update and timeline were presented. A framework for moving forward on binning the genome was clarified. Four aspects of the charge to the BSC from the September 2011 meeting were presented in the form of questions: Should NHANES change its genetics consent to report back genetic results? Is binning the genome a good response for NHANES with regard to the initial guidelines on what to report back? Who should determine which Bin 1 findings meet a dire duty to warn threshold for the NHANES setting? Can this model be applied to all surplus biological specimen projects? The final question has not yet been addressed.

Discussion Questions focused on updating contact information; and whether to re-contact participants with an opt-in or opt-out choice, given the costs and potential worry to respondents. The entire landscape could change in a year relative to the ethics of reporting back findings from biobank genetic specimens and also with regard to how genetic research is conducted. Risk/cost benefits must be determined. Bin 1 is expected to grow as science moves forward and new treatments are developed. Technological advances may result in identification of incidental clinically actionable cases. Individuals' desire to know also varies. Action must occur prospectively for future participants and retrospectively for responders who have been told something else.

A proposed "conference" of participants who could advise NCHS on issues relevant to a broader constituency was suggested. Discussion ensued about BSC's interface with such an advisory board relative to Bin 1 activities; consent form revisions; and psychological distress of respondents who are told they may need to be re-contacted. The BSC was asked to provide advice to NCHS by May 2012. One big question is how best to get the genetics program moving. Relative to the ERB ruling, it is possible to provide additional information and even request a pilot program for revised protocol. Also discussed was the representative nature of the Affymetrix genome-wide human SNP array 6.0 chip data; and how often these issues would occur within the NHANES sample world. A pilot program was suggested, more specifically, use of the Affy chip as a pilot test before implementing a re-consent process. Liability questions were raised. The binning process is an easier question that that of informed consent.

A new consent form must be piloted and pre-tested but is a May deadline feasible? Does BSC recommend that NCHS pilot the consent form with variations as it determines its role relative to staff? A suggestion was made to approach ERB with recommendations for consent form improvements. The re-contact issue should be dealt with separately and the question of psychological stress should not be trivialized. In 2009 and at the 2011 meeting, the Ethics Committee reiterated that blanket non-disclosure is not appropriate. Even when getting past the dire duty to warn threshold, a more considerate, informed, deliberate process that examines informed consent is needed for the future as well as a policy for what already exists. Discussion ensued about whose obligation it is to inform responders of specific dire results and how the words “ethical” and “appropriate” are used. Regardless, NHANES will take action in May 2012 without extensive pilot testing. Binning should move forward with an understanding of what Bin 1 variants must be reported back. Psychological distress could be addressed as part of the piloting evaluation. As EGAPP cannot determine what gets reported back to respondents, a separate process must be established and remain independent. Dr. Cain will draft ideas from the genetics program discussion for distribution and discussion on February 10, 2012.

Health Indicators Warehouse

Amy Bernstein, D.Sc., Chief, Analytic Studies Branch, OAE

A brief overview was presented as were accomplishments to date, in the areas of general systems releases and enhancements; web services development; internal process development and improvements; outreach and engagement with user communities; governance; and user analytics. Proposed future activities, funding, ownership and key stakeholders were delineated.

A BSC subgroup is helping to determine how indicators should be proposed. Although the Warehouse has been up since late September and live since December 2011, no one has proposed a new indicator to date. NCHS would like BSC’s advice on how to work with indicator contributors in a way that ensures high quality. Different stratification variables for different years were noted, requiring “cleaning up” the site. The next Warehouse version will allow for simple line trend charts that selectively filter information (due to be up by March 2012). Meta-data or methodology has been separated from actual data. Systems to update Warehouse information are in place. Currently, the main issue is how to ensure quality in a process managed by people with many competing demands for their time.

Discussion To date, the process of accepting new indicators has been informal. Advice is being sought on how to modify a currently onerous indicator selection process as opposed to finding new partners. Warehouse users must be identified. The new interagency Indicator Advisory Group can provide guidance about priorities and guidelines development. Similarities of the Kansas *Health Matters* program to the HIW were described. A suggestion was made for the HIW to link up with CDC’s environmental public health tracking program and, in general, to collaborate more with state web-based query systems. Marketing was discussed, emphasizing the HIW as a dissemination tool and noting an evaluation component. While more outreach and evaluation are needed, a dramatic use increase since December 2011 was noted.

NCHS Survey Planning Process – Increasing BSC Involvement

Edward Sondik, Ph.D. and Lee Cornelius, Ph.D.

The complicated process of determining survey content must take timing, a review process and guidance from Congress into consideration. NCHS's responsibility is to predict what Congress and federal collaborators will do in order to establish baselines. More collaboration and coordination with state agencies is desirable. Funding uncertainties include the possibility of a 25% drop or increase. The questions was raised as to whether a BSC subcommittee should be formed to help members understand these issues and provide guidance on goals or content, research or policy issues; social media; and use of NHANES variables and early release.

Discussion It was suggested that the BSC examine current and future survey content and that workgroups be formed to review different surveys. Others thought that BSC should not get involved with crafting survey questions. Information about survey review scheduling was requested. The idea of contrasting NCHS and NHANES to maximize the value of using one or both was lauded. A suggestion was made to utilize individual BSC member expertise on specific surveys as a feedback mechanism for a longer-term global view.
The meeting was adjourned at 5:00 p.m.

Friday, February 10, 2012

Ambulatory Hospital Care Statistics Branch (AHCSB) Review

Neil Powe, M.D.; Paul Beatty, Ph.D., Holly Hedegaard, M.D., José Escarce, M.D.

Dr. Powe described the review process, including membership, structure and presenters. Reviewers examined organization staffing; budget; various surveys (e.g., ambulatory care and hospital care); accomplishments, contributions and collaborations; data products and dissemination; data users and uses; and the need to respond to emerging data needs. The adoption of electronic health records; utilization; diagnostic testing in outpatient settings; and the optimal use of testing, particularly in physician offices, were important considerations. A shift from inpatient to ambulatory surgery in the United States was noted. Staffing issues were discussed in greater detail. More targeted survey data is needed that focuses on patient characteristics and healthcare costs. Future considerations emphasize comparative effectiveness research measured by patient outcomes as well as social determinants of health care.

Progress should be accelerated in the use of electronic medical records (EMRs); data collection computerization; content expansion; survey design enhancement that includes longitudinal analyses; and survey capacity enhancement to add specific components. In the content area, more can be learned about how medical practice is organized. Surveys should disseminate information about models and bolster emphasis on post-acute settings. Audits are needed to track accuracy of new electronic data collection methods. Developing more survey stakeholder involvement and funding is desirable. The Branch has created a new data brief and is considering further use of social media for dissemination purposes. Outreach opportunities were outlined. A collaborative extramural funding or grants program could encourage the use of national health statistics data. Gathering longitudinal data in areas such as cardiovascular disease is recommended. Recently, the Branch underwent a successful strategic planning process and it was suggested that such planning become a permanent part of Branch operations.

Dr. Beatty described how rapid healthcare changes have impacted the Branch and NHAMCS. Intertwining key challenges including timeliness and an ability to respond to emerging needs were outlined as were new 2012 products and dissemination. Dr. Hedegaard focused on survey content suggestions and data quality issues. A suggestion was made to gather information about the 2013 ICD-10-CM implementation from the physician workflow supplement. Cost information should be captured on the new National Household Care Survey. The more the surveys capture information not available in administrative data sets, the more valuable the data become. There is potential to provide useful information and national estimates to trauma systems and hospitals. Now is a good time to reengage HRSA around the children's hospital surveys. The extent to which ambulance diversion is a problem relative to increased ER visits should be tracked. Reabstraction is very important. Capturing narrative information for comparability studies is useful to states and many organizations in relation to ICD-10-CM. For data quality purposes, the pros and cons of abstracting data verses EHRs is valuable information for researchers.

Dr. Escarce noted that the incorporation of laboratory studies and the look-back module provides an opportunity to learn how doctors handle certain chronic diseases such as diabetes, hypertension and risk factors for cardiovascular disease. How well and often are medical practice and healthcare delivery arrangements within ambulatory practices managed in relation to chronic conditions and emerging trends? Revisiting measurements of current medical practice characteristics would be useful. A suggestion was made to alter the survey design in order to vary sites and years so that input does not always come from the same PSUs (although it was noted that PSUs have been replaced by a list sample in order to produce conditions and national and state estimates). The Branch hopes to build a platform for supplemental information such as children's hospital data; staffing capacity ambulance dispersion; and asthma and cervical cancer, some of which depend on what is important in any given year. Engaging partners and stakeholders to determine pressing needs was recommended.

Discussion Conversion to ICD-10-CM involves many physician issues that require further exploration. To understand the main characteristics of medical practice, the content of the NHAMCS provider questionnaire should be reconsidered. AHQR and HCUP collaborators have been good partners but some functions distinctly belong to the Branch (e.g., linking data sources within and beyond hospitals). It is important to get the hospitals on board; to keep producing national estimates; and to remain sustainable. It was noted that some hospitals suggest that information be gathered from health information exchanges (HIEs), which may not be efficient. The prison healthcare survey, not yet in the field, covers a "huge" knowledge gap area. Obtaining more direct patient-level data within prisons is also stalled although information is being gathered in community-hospitals.

Dissemination constraints were further discussed. Constraints in physician data sets are related to confidentiality. Data briefs have replaced longer reports within ongoing outreach efforts. It is useful to be aware of what others outside of the federal government are doing in quality improvement. A suggestion was made to begin gathering health care information from individuals rather than from healthcare providers. It was noted that the somewhat isolated DHCS has not fully capitalized on collaborations although steady dialogue exists with OAE. In part, this is due to having different data collection methods (data comes from medical visits rather than people) and in part, they are about 15 years behind in moving to electronic data collection. Although complicated, it is possible for the Branch to collect more information about people and institutions.

A suggestion was made for the Branch to obtain releases and to meet with people when gathering survey data. A concern with the current look-back mechanism was mentioned in that medical services to individuals from other than personal physicians are not taken into account. The MEPS survey gathers such information. Administrative data can be linked by bringing the same PSUs together. For people over 65, the link is to Medicare data but for those under 65, the names of physicians are needed for follow-through, which is very costly. The ideal design would be to use both methods of following providers and people but it would double or triple the cost of current surveys.

Vital Statistics reports do not always match Branch data. An analysis of estimates from the two surveys is done as a quality control. Is there an intermediate approach? The fact module is hard to analyze due to selective behavior of different types of patients. The provider group is working to get ahead of the electronic curve, which will completely change how data collection is done and the private sector (e.g., AHA) is collecting the same sort of data. Ideally, all data would be available and integrated at a patient- or practice-level. The look-back approach was further discussed. With the right expertise and an appreciation of the importance of creating a network view of care, the Center could have significant impact on these healthcare concerns.

The BSC accepted the report in full as is. A discussion of the cover letter to Dr. Sondik ensued and Drs. Hedegaard and Escarce were recruited to develop a draft.

Early Release Program for Early Release of Reports and Early Availability of Data from the National Health Interview Survey

Jane Gentlemen, Ph.D.

Background was presented on the early release program for reports and data availability from the National Health Interview Survey (NHIS). A question was posed about what of the 15 key health indicators to change. In general, the program justified reasons to keep flat trending indicators in the quarterly report. The first four stand-alone reports (out in March and April 2012) were described. The Crosswalk of 15 Key Health Indicators from the NHIS's Early Release Program with the *Healthy People 2010* hand-out was reviewed. Despite some being relatively flat, justifications exist for keeping all but the personal care needs indicator.

Discussion For consistency across departments, a suggestion was made to add another column to the OAE key indicators table that determines whether indicators are dashboards. A dashboard is a set of measures that provides a comprehensive picture of how something is working. Discussion ensued about whether and why to include HIV testing on the indicators list and whether (and what kind of) a more general chronic disease indicator should be added. There is much overlap between the *State of the USA Project* (currently on hold) and the *Key National Indicator Project*. While there are fairly extensive microdata from each quarter in the Research Data Center (RDC), it is not publically available although that data can be accessed at the Center or remotely. Clarification was sought about the difference between *Healthy People* objectives and leading health indicators.

DHHS Data Standards

Virginia S. Cain, Ph.D.

A PowerPoint presentation described data standards developed to better understand health disparities (i.e., race, ethnicity, sex, primary language and disability). BSC was asked to identify whether other areas need standards (e.g., socio-economic status). Standards requirements were delineated. Several committees developed criteria with a guiding principle of disaggregation, focusing on minimum survey data standards. The specifics of disaggregated categories were mentioned. The recommended standards (adopted October 31, 2011) apply to new surveys and for the next major revision of existing surveys.

Discussion The specifics of Asian and Hispanic groupings were discussed. In considering where to go next, HHS may explore recommendations for record and surveillance systems. Concerns were raised about comparability of new survey measurements relative to traditional OMB measurements. How recommended categories are administered will depend upon the survey. Several BSC members advocated for consistency, challenging the fact that some groupings are not derived from numeric considerations while others are. That some gathered data will never be seen was noted as problematic. Comparability was further discussed. NHANES's huge list of ethnicities or nationalities is intended to help with coding rather than analysis.

National Committee on Vital and Health Statistics Update and Hearing on Measuring Socioeconomic Status (SES) in Surveys **Marjorie S. Greenberg**

An NCVHS fact sheet was distributed, noting NCVHS's website: www.ncvhs.cdc.gov. Ms. Greenberg (email MSG1@CDC.gov), NCVHS's temporarily liaison to the BSC, informed the group that a new liaison from the BSC to NCVHS is in the process of being selected, noting overlap between the two groups in areas such as population health data. NCVHS's four subcommittees were delineated. A 2011 NCVHS report entitled, "The Community as a Learning System: Using Local Data to Improve Local Health" was distributed.

BSC members were invited to an NCVHS hearing (March 8-9, 2012) to consider socio-economic status as a minimum standard for federal surveys. The Committee's short-term objective is to help the Department make a recommendation on a minimum standard. A subcommittee follow-up in April 2012 will develop recommendations for the National Committee's June 20-21, 2012 meeting. The Committee's long-term objective involves further study of social determinants of health. A joint hearing workshop with BSC and NCVHS members may occur in the future.

Discussion A discussion ensued about how immigration has changed how we look at inequality in the U.S. SCS measures may operate differently among immigrants. Survey questions asking about parental ethnicity should be considered. Further exploration of the British "Super Diversity" construct (focusing on interaction between race ethnicity in SCS and other dimensions) was recommended. A possible immigration survey is being considered and certainly, immigration can be a topic for further consideration. The importance of the liaison role for both committees was reiterated.

Wrap-Up and Input for Draft Letter about NHANES DNA Program

Dr. Virginia Cain, Executive Secretary

A rough draft of the letter to be sent to Dr. Sondik was submitted to BSC members for revision. It was suggested that the consent form be modified, noting that the "how" would depend upon whether the work has advanced enough to allow for suggestions that meet OMB standards. Until the work allows for a change, the old form could be used. Dr. Cain will refine the letter and send it to BSC members for commentary.

The meeting was adjourned at 12:12 p.m.

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

-s-

Chair ____________________ DATE ____________________

Attendees

Staff and Liaisons

Clarice Brown, Director, Division of Health Care Statistics
Virginia S. Cain, Ph.D., Executive Secretary
Jane Gentleman, Ph.D., Director, DHIS
Marjorie S. Greenberg, Executive Secretary, NCVHS (2-10-2012 only)
Cliff Johnson, Director, DHIS
Jennifer Madans, Ph.D., NCHS
Charles Rothwell, M.S., Director, Division of Vital Statistics
Nathaniel Schenker, NCHS
Edward Sondik, Ph.D., Director, NCHS

Presenters

February 9, 2012

Amy Bernstein, Sc.D., Chief, Analytic Studies Branch, OAE
Lisa Broitman, M.P.A., Deputy Director, DHANES
Llewellyn Cornelius, Ph.D., Chair, BSC
Rosemarie Hirsch, M.D., M.P.H., Deputy Director, DHANES
Charles Rothwell, M.S., Director, Division of Vital Statistics
Edward Sondik, Ph.D., Director, NCHS

February 10, 2012

Paul Beatty, Ph.D., Chief, AHCSB, Division of Health Care Statistics
Virginia S. Cain, Ph.D., Office of the Center Director
José Escarce, M.D., Ph.D., BSC Liaison to the AHCSB Review Panel
Marjorie S. Greenberg, Executive Secretary, NCVHS
Holly Hedegaard, M.D., MSPH, BSC Liaison to the AHCSB Review Panel
Neil Powe, M.D., AHCSB Review Panel Chair

Others

February 9, 2012

Victoria Albright, RTI
Rosa Avila, NCHS
Vicki L. Blut, DHANES
Lori Borrud, DHANES
Verita Buie, NCHS
Jim Craver, NCHS
Sandra Decker, NCHS
Alyson, Essex, DHCS
Rebecca Hines, OAE
Dale Hitchcock
Lillian Ingster, DVS
Debbie Jackson, NCVHS
Katherine Jones, CPHDSS
Dean Judson, NCHS
Diane Makin, OAE
Peter Meyer, NCHS
Kathy Moss, OPBL
Jody McLean, DHANES
Gerry McQuillan, DHES

Mary Moien, NCHS
Tatiana Nwankwo, DHANES
Jennifer Parker, NCHS
Iris Shimizu, ORM
Sandy Smith, NCHS
Susan Queen, ASPE
Makram Talih, OAE
Stephanie Ventura, DVS
Kassi Webster, OPBL
Libet Zhen, NCHS

February 10, 2012
Lara Akinbami, OAE
Victoria Albright, RTI
Brenda Baker, DHIS
Paul Beatty, DHCS/AHCSB
Carol DeFrances, DHCS
Alyson Essex, DHCS
Marni Hall, DHCS
Shaleah Levant, DHCS
Don Malee, ORM
Michael Martinez, DHIS
Iris Shimizu, ORM
Makram Talih, OAE
Kassi Webster, OPBL