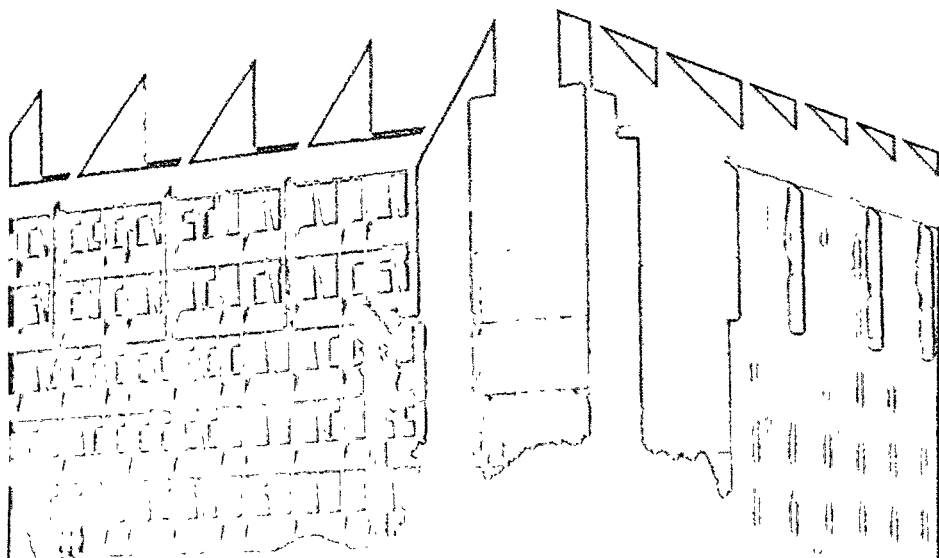


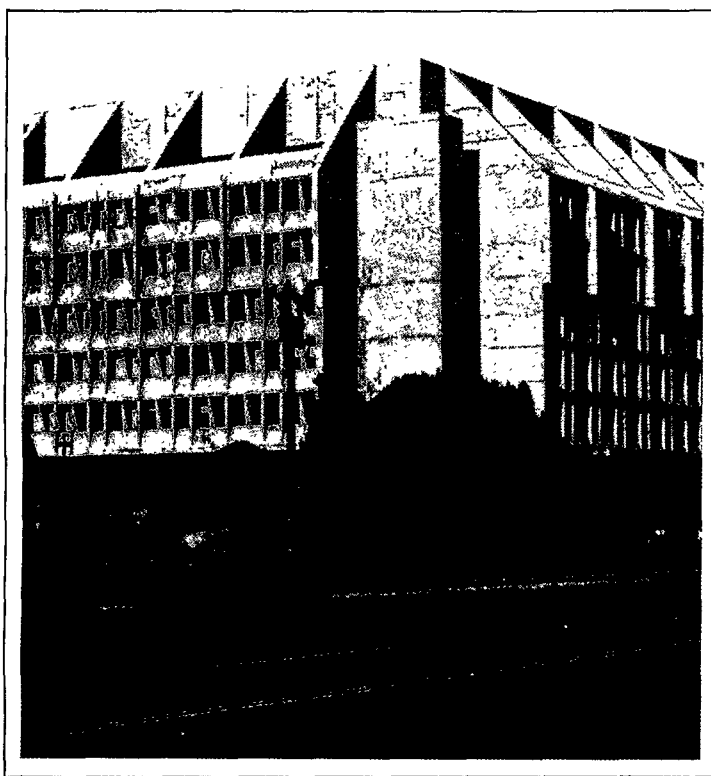
The National Committee on Vital and Health Statistics

1983-85



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DHHS Publication No. (PHS) 86-1205

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Center for Health Statistics

Hyattsville, Maryland
March 1986

Robert H. Barnes, M.D.
1014 East Blaine Street
Seattle, Washington 98102

The Honorable Otis R. Bowen, M.D.
Secretary, Department of Health
and Human Services
Washington, D.C. 20201

Dear Secretary Bowen:

On behalf of the National Committee on Vital and Health Statistics, I am pleased to transmit the summary report for Fiscal Years 1983-1985 as required by the Committee's Charter.

As you read this report it will become apparent that the Committee has been very active on practical issues related to health statistics that are vitally important to the Department and its programs. In addition to these substantive aspects of the Committee's work, it has helped strengthen working relationships between components of the Department, particularly between the Public Health Service and the Health Care Financing Administration; it has served as a conduit for an exchange of views between State governments and your Department; it has been a forum where professional medical associations could voice their concerns; and it has developed improved channels of communication from the national medical community to the World Health Organization.

Since this is a continuing advisory committee we have indicated in the report some of the current and planned activities of this body and remain ready to serve the Department as you may require.

Sincerely,

A handwritten signature in dark ink, reading "Robert H. Barnes, M.D." with a stylized flourish at the end.

Robert H. Barnes, M.D.
Clinical Associate Professor of
Medicine and Public Health
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and Chairman
National Committee on Vital
and Health Statistics

FOREWORD

During the last 5 years, dramatic changes have taken place in the health field, particularly in health care delivery, financing, and technological breakthroughs. As part of this change, the Federal Government has implemented the Diagnosis Related Groups (DRG's) prospective pricing plan for hospitals, has frozen Medicare payments to physicians, and is examining new payment mechanisms for physicians. The Health Care Financing Administration (HCFA) has contracted with a vast number of Professional Review Organizations (PRO's) to monitor the health care system to control costs and assure quality care. Paralleling these activities, technological developments and increasing numbers of elderly citizens requiring long-term care contribute to the possibility that the cost control efforts may not be fully effective.

What might seem at first glance to be a minor issue compared with the above dramatic ones is the use of the World Health Organization's International Classification of Diseases (ICD-9) to code the financially driven DRG pricing system. One legitimate concern of epidemiologists and statisticians is that health data will be biased by using the coding system for a purpose for which it was never devised. In the meantime, the World Health Organization (WHO) continues to pursue a current 15-year revision process of the ICD with a goal of updating the system for capturing mortality and morbidity data internationally. The global scope of usage detracts from the ability of WHO to focus upon the specific issues concerning the United States.

Within this atmosphere the National Committee on Vital and Health Statistics (NCVHS) has sought to advise the Secretary of Health and Human Services (HHS) on health statistics. A variety of NCVHS accomplishments regarding some of the aforementioned issues are included in this report.

The National Committee for Vital and Health Statistics is composed of 15 members appointed by the Secretary of Health and Human Services. The skills of the group have changed over the years from highly technical expertise in health statistics and epidemiology to that of a more diversified group. It now encompasses, in addition, practicing physicians, teachers in medicine, leaders in the health insurance industry, and managers of State health programs.

The strength of the Committee derives from the experience, dedication, and commitment of its members, plus excellent staff support from the National Center for Health Statistics (NCHS). The Congressional charter for the National Committee on Vital and Health Statistics provides for continuity and stability. The Committee has ready access to the highest levels of government in the health care field. Over the last 2 years, its relationship to the Health Care Financing Administration, particularly with the Office of Data Management and Strategy, has been enhanced. The former Assistant Secretary for Health, Dr. Edward Brandt, solicited specific products and reports from the Committee and indicated that the Chairman of the Committee should be present when results were presented to the Health Information Policy Council (HIPC) of the Department of Health and Human Services.

The Committee's meetings have become a forum for the discussion of frequently complex and sometimes conflicting opinions about statistical needs for a variety of current national issues. In addition, special meetings have been arranged to facilitate enhanced communication when the need was recognized. For example, three conferences focusing upon the ICD-10 revision process were cosponsored with NCHS for the users of ICD. The information gathered at these conferences will be utilized in communicating with WHO to reflect some of the concerns within the United States.

The Committee utilizes its subcommittee structure to focus attention on priority topics. These topics are selected by the Department (through the Health Information Policy

Council, the Assistant Secretary for Health, NCHS, and/or the Committee itself. The fragmented and sometimes uncoordinated nature of health data and health statistics programs pose problems of uniformity and magnitude. Data flow nationally from literally hundreds of sources -- State and local governments, insurance companies, and research institutions. It is not a goal of the Committee to develop or stimulate a single national health data statistics system, but it is an objective to seek uniformity for purposes of comparability where appropriate. The development of minimum health data sets -- the Uniform Hospital Discharge Data Set and the Long Term Care Minimum Data Set, and, eventually, the Ambulatory Care Minimum Data Set -- represents steps in that direction. Support for cooperative health statistics activities among Federal, State, and local governments exemplifies the coordinating role of the Committee.

Concern must be expressed about the effect of resource restrictions upon data collection systems and data support services. The impact of inadequate support could be detrimental to medical research and health policy.

The National Committee for Vital and Health Statistics is an effective force. With the continued support of the Department of Health and Human Services and the National Center for Health Statistics, it will continue to influence national, State, and private information systems. It will also continue to provide a forum for the users of health statistics.

Robert H. Barnes, M.D.
Chairman, U.S. National Committee
on Vital and Health Statistics

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EXECUTIVE SUMMARY

During the 3 fiscal years 1983, 1984, and 1985, the National Committee on Vital and Health Statistics and its subcommittees have completed or are addressing important assignments conveyed initially in 1983 by the Department of Health and Human Services (DHHS). The Committee was requested to evaluate and advise the Department on the following:

- The revision process of the International Classification of Diseases (ICD) and the participation of all concerned parties.
- The Uniform Hospital Discharge Data Set (UHDDS).
- The Long Term Care Minimum Data Set (LTCMDS).
- The Vital Statistics Cooperative Program (VSCP).

In response to these charges, the Committee has provided a forum for the ICD revision process including sponsoring a national conference on this subject; has reviewed and proposed revisions to the Uniform Hospital Discharge Data Set; is currently reviewing the Long Term Care Minimum Data Set; and has consulted with States and involved Federal agencies and made recommendations to the Assistant Secretary concerning the Vital Statistics Cooperative Program.

The Committee is also identifying and clarifying issues and problems that it can address; the most appropriate techniques for dealing with them; the relationship of the Committee with external organizations and advisory groups; and the most effective organization and procedures to advance the Committee's work. An executive subcommittee was established in November of this year to maximize the efficiency and effectiveness of the performance of NCVHS.

Priorities identified for fiscal year 1986 include the following:

- Complete the review of the Long Term Care Minimum Data Set.
- Monitor the continuing ICD revision process and serve as an arbiter, as requested, to resolve alternative proposals.
- Monitor the impact of the DRG prospective payment system on health statistics for hospitalized patients.
- Monitor proposals for prospective physician reimbursement for ambulatory care in terms of any impact on health care statistics and their ability to measure quality of health care.
- Encourage and monitor efforts to develop a single system for coding procedures provided by physicians.
- Review and make recommendations regarding the collection and distribution of minority health data.
- Make recommendations as to how to close the data gaps in disease prevention and health promotion.

**ACTIVITIES AND ACCOMPLISHMENTS OF THE
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS,
FISCAL YEARS 1983-85**

At its first meeting in February 1983 following a hiatus of nearly 2 years, the Committee was addressed by Dr. Edward Brandt, Assistant Secretary for Health, who expressed his interest and concerns and indicated ways in which the National Committee could assist the Department. He noted that the newly formed Health Information Policy Council (HIPC), a Departmental statistical advisory committee which he chaired, would be reviewing Departmental statistical systems to determine how comparability could be enhanced and multiple purposes be served. The Council found 466 separate health data collection systems within the Public Health Service (PHS) alone, many of which were incompatible because of different definitions and criteria.

A second area of concern was to determine how the National Center for Health Statistics and other elements of the Public Health Service could interact with the academic community, governmental agencies at State and local levels, and the private sector to avoid duplicate data collection, to share data more readily, and to use resources collectively to enhance statistical products.

Dr. Brandt invited the Committee to provide advice in both of these areas in addition to any other areas where the members felt the Department could benefit from their advice.

The Health Information Policy Council met soon thereafter on May 3, 1983, to review and discuss a background paper on Uniform Minimum Health Data Sets as a mechanism for improving data comparability from various sources. There were five Uniform Minimum Health Data Sets waiting action by the HIPC at that time. Three of them had been developed and recommended to the Secretary by the National Committee on Vital and Health Statistics: the Uniform Hospital Discharge Data Set, the Long Term Care Minimum Data Set, and the Ambulatory Care Minimum Data Set. The others, the Health Care Facilities Data Set and the Health Manpower Data Set, had been developed by the National Center for Health Statistics.

Based on a consideration of the then current issues and those anticipated, the Health Information Policy Council decided that action on the Uniform Hospital Discharge Data Set (UHDDS) was of the highest priority, followed in priority by the Long Term Care Minimum Data Set. With respect to the Uniform Hospital Discharge Data Set, the HIPC requested the National Committee to evaluate the effectiveness and comprehensiveness of the current data set in terms of current trends and identified problems. This review was to be conducted in conjunction with an interagency task force within the Department representing agencies which would be affected by any changes. The Health Information Policy Council asked for a written report on this review by September 1, 1983.

With respect to the Long Term Care Minimum Data Set, the HIPC requested the National Committee to review the findings and recommendations of a field test of this data set in light of present needs and issues and to reduce the current data set to a truly minimum core if possible. This review was also to be conducted in conjunction with a Departmental Uniform Hospital Discharge Data Set Interagency Task Force and a written report provided to the Health Information Policy Council.

During the Spring of 1983, the Public Health Service received comments from physician specialty associations expressing concern with the review process used in the United States to develop the ICD-9. These groups urged that they be given an opportunity for input into the 10th revision of the International Classification of Diseases. The Committee was charged to address this issue to facilitate input from these groups.

A continuing issue for the National Center for Health Statistics and the Assistant Secretary for Health has been the negotiations with the Association of Vital Records and Health Statistics regarding the Federal Government's proper share of the funding for the national vital statistics system. An earlier joint task force had developed a formula for determining costs incurred by the States but could not agree on the appropriate division of these costs between the State and Federal governments. The Committee was directed to address this issue.

As a result of the above events, at the June 1983 meeting of the full Committee, it was agreed to establish three subcommittees in the following areas: Uniform Minimum Health Data Sets, the Vital Statistics Cooperative Program, and Disease Classification and Automated Coding of Medical Diagnosis. Subsequently, work groups were established on Statistical Aspects of Physician Payment Systems (May 1984), Review of Publications (May 1984), Minority Health Data (December 1984), Data Gaps in Disease Prevention and Health Promotion (December 1984), and an ad hoc subcommittee on Policy and Direction for the National Committee on Vital and Health Statistics (June 1985). Membership lists and the charges to all subcommittees and work groups are included as the appendixes to this report. The activities and accomplishments of each subcommittee and work group are described below.

Policy and direction

At the June 1985 meeting of NCVHS, the members agreed there was a need to examine a variety of issues related to the structure and functions of the Committee.

The Chairman appointed an ad hoc Subcommittee on Policy and Direction which met on September 27, 1985, to discuss these issues and to define ways to improve the effectiveness and efficiency of the Committee. Among the issues discussed were the following: the mechanisms for identifying and selecting topics for NCVHS consideration; the relationship of the NCVHS to a wide variety of public and private organizations; the role of the NCVHS in the appointment and orientation of new members; and administrative problems related to the functioning of the Committee and its subcommittees. The Committee disbanded the ad hoc Subcommittee on Policy and Direction at the November 1985 meeting and established a permanent executive subcommittee chaired by the Chairman of the National Committee on Vital and Health Statistics.

Uniform minimum health data sets

The Subcommittee on Uniform Minimum Health Data Sets held meetings on July 27-28, November 4, and December 6-7, 1983 and heard testimony from the major organizations involved with using the Uniform Hospital Discharge Data Set (UHDDS) and knowledgeable private individuals. Representatives of the Departmental Uniform Hospital Discharge Data Set Interagency Task Force were present at all meetings and several gave testimony.

The final report of the Subcommittee was presented and approved by the full Committee on February 28, 1984, and transmitted to the Assistant Secretary for Health, Dr. Brandt, on March 1, 1984. The report notes that there was a nearly universal acceptance of the Uniform Hospital Discharge Data Set by all parties and that it was serving a wide range of uses.

The Subcommittee recommended some additions, deletions, and modifications of data elements. It also submitted a set of ancillary recommendations related to the implementation and maintenance of the data set.

Briefly these ancillary recommendations were as follows:

- Adoption of uniform face sheet in hospitals.
- Development of a uniform system of codes for the UHDDS.

- Development of a broad educational program.
- Development of regularly updated instruction manuals and materials.
- Development of a continuous system for assessing data quality.
- Study of the uses of UHDDS.
- Performance of feasibility studies to investigate the linkage of records across episodes of illness, across hospitals, and within hospitals.

At the April 12, 1984, meeting of the Health Information Policy Council (HIPC), the recommendations of the Departmental Interagency Task Force on the Uniform Hospital Discharge Data Set and the report of the National Committee on Vital and Health Statistics on the UHDDS were reviewed. The HIPC agreed to the separation of "race" and "ethnicity" data elements, the categorization of procedures into classes was eliminated and the definition of "significant procedure" modified, and a few other minor changes were made to the original Uniform Hospital Discharge Data Set.

The 1984 revision of the Uniform Hospital Discharge Data Set for use within the Department of Health and Human Services was approved by the Secretary, DHHS, on December 12, 1984, and published as a notice in the Federal Register on July 31, 1985. The revision is to be implemented in all appropriate programs of the Department by January 1, 1986.

The Committee intends to monitor (1) the implementation of the UHDDS within the Department and in the private sector; (2) the development of a broad educational program including instruction manuals and training materials; and (3) the development of a mechanism for periodic review. Areas needing further attention are the adoption of a uniform face sheet in hospitals, a uniform system of codes for UHDDS items to permit sharing of data tapes, and feasibility studies on various types of record linkage.

The Subcommittee on Uniform Minimum Health Data Sets next turned its attention to the Long Term Care Minimum Data Set in April 1984 and is continuing to review the uses and need for the data set items with various experts in the medical care community and with members of the Department's Interagency Task Force on this subject.

This data set is much more complex than the one for hospital discharges because of the diversity of facilities and programs providing long-term care, and the range of services in each facility. There is also a problem in defining when the data should be collected (at the time of admission, at the time of discharge, or on some periodic basis, such as annually).

The Subcommittee has basically completed hearings on the original data set and the reasons for inclusion or exclusion of certain items. It now has three general directions: To obtain more knowledge of the potential effects prospective payment systems will have on data requirements; to learn more about facility and program management needs for data; and to organize, outline, and report its findings and recommendations.

Vital Statistics Cooperative Program

In 1981, in response to concerns expressed by State representatives about the contracts procedure and some inequities in funding criteria, a Working Group on the Completion of the Vital Statistics Cooperative Program (VSCP) was appointed by the Director of the National Center for Health Statistics to develop recommendations regarding the following: (1) the completion of the VSCP at a realistic level of funding, (2) the standardization of criteria to assure more equitable funding among the States, and (3) the simplification of the contracting process for all vital statistics activities.

The completed report was submitted to the Director, NCHS, in May 1982 but the group, composed of representatives from the States and the National Center for Health Statistics, could not reach agreement on all topics. They agreed on a formula for defining activities

within the scope of the program and estimating costs. They also agreed on methods for simplifying the contract process. Agreement was not reached on the portion of costs to be borne by the Federal Government, nor on the priorities for which new budget funds should be used.

Continuing discussion on these two issues resulted in the establishment of the Subcommittee on the Vital Statistics Cooperative Program in June, 1983 to review and assess the issues and make recommendations. First, the Subcommittee heard testimony from a panel of representatives from State vital statistics and registration offices, who informed the members about the operation of the national vital statistics system, the perceived inequities in the funding of the system, and the impact that reduced financial resources had had on the quality and timeliness of data.

Next, the Subcommittee met with representatives from Federal agencies who use data from the vital statistics system as an integral part of their programs. All testified to the importance of vital statistics data, to their agencies' dependence upon it, and to the good working relationships they had experienced with the National Center for Health Statistics. Many representatives believed timeliness was a problem and most said they would be willing to encourage their agencies to provide support for the VSCP, or to document the need for appropriate support.

After thorough review and discussion of all available written materials and oral testimony, the Subcommittee made its recommendations to the full Committee in September 1984. The National Committee on Vital and Health Statistics accepted the recommendations and transmitted them in a report to the Assistant Secretary for Health on November 27, 1984.

Briefly, in the report, the National Committee on Vital and Health Statistics:

- Endorsed the cost formula developed in 1982 by the Working Group on the Completion of the Vital Statistics Cooperative Program with the proviso that it be reviewed after 5 years' experience.
- Recommended that NCHS seek to achieve funding for the Vital Statistics Cooperative Program at the 33 1/3 percent level in fiscal year 1985 and offered alternatives on how this might be accomplished.
- Decided that users' fees are not a feasible source of additional funding.
- Endorsed as a matter of principle the 50 percent level of Federal financial participation in the funding to be achieved at some point in time and recommended that NCHS should prepare a plan to achieve this.
- Recommended that NCHS should set a goal of completing the VSCP system by 1987, setting the Federal share between \$11.4 and \$17 million.

In a letter to the NCVHS Chairman on January 17, 1985 the Acting Assistant Secretary for Health responded to the recommendations. He found the report to be a good basis for cooperative relationships with the States and supportive of the Public Health Service goal to raise the Federal share to 33 1/3 percent over the next several years. He did not think it possible to seek additional appropriations for this purpose in FY 1985 because of budgetary constraints. Any additional support above the 33 1/3 percent level would be considered only after that level has been achieved and then only after a thorough reevaluation.

Disease classification and automated coding of medical diagnoses

The official charge to the Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses, established in June 1983, noted some of the recent developments which have an impact on disease classification and their complex interrelationships. The Subcommittee was charged to review these interrelationships to determine where there must be close coordination and where independent development can proceed.

The primary mechanism the Subcommittee chose to accomplish its tasks was to receive testimony from the many organizations in the private sector and in State and Federal government that are vitally interested in this subject. Representatives from these groups presented the medical, political, economic, and technical issues surrounding the classification and coding of diseases and procedures. With respect to the development of the 10th revision of the ICD some professional associations clearly had felt excluded from the 9th revision process. They expressed concern about the process for the 10th revision. Another frequently expressed opinion was that the United States had not stated its case strongly enough at the World Health Organization (WHO) meetings and conferences during the last revision cycle.

In response to such testimony, the NCVHS Chairman was invited to the meeting of the Heads of the Collaborating Centers of WHO in San Francisco during June 1984 to learn first-hand about the revision process and the opportunities for participation. Subsequently, the Committee agreed to collaborate with NCHS in presenting three conferences to orient ICD users in the United States about the revision process and to provide them with an opportunity to take an active role.

A conference for the Federal agencies was held in December 1984 and a national conference for medical specialty groups and other interested organizations met on May 1-2, 1985, in Bethesda, Maryland. Both meetings solicited comments on changes needed in the ICD, and at the close of the May meeting there was a call for agencies willing to serve as focal points for chapters of the ICD. Twenty organizations volunteered their services to solicit and coordinate comments for particular areas. A third conference is planned for those concerned with the implementation of ICD-10 from a data collection and processing perspective. The use of a combined alphanumeric code, new tabulation lists, and other changes will call for major adjustment. The NCVHS believes that these three conferences will clarify the ICD revision process for many different organizations that previously felt uninformed and not part of the process.

The Subcommittee will continue to serve as sounding board for those groups in the United States who have special concerns about disease classification and will attempt to resolve differences among various medical specialties regarding placement of specific conditions within the ICD structure.

The Subcommittee has kept informed about the implementation of the prospective payment system in hospitals for Medicare patients and the use of Diagnosis Related Groups (DRG's) to help determine the level of payment. There is much concern regarding the impact of this system on the quality of health care data, particularly diagnostic information, and trend information on hospital utilization. The Subcommittee intends to continue monitoring studies by the Prospective Payment Assessment Commission, the Health Care Financing Administration, and others to determine what effect this new payment mechanism is having on the documentation and coding of diagnoses.

The Subcommittee heard from various organizations involved with the development, maintenance, and use of procedure codes, consisting primarily of the American Medical Association's Current Procedural Terminology (CPT-4) and the procedural codes accompanying the International Classification of Diseases, 9th Revision Clinical Modification (Volume 3 of ICD-9-CM). CPT-4 is the core system adopted by HCFA in its HCFA Common Procedure Coding System (HCPCS) and is used by physicians in fee-for-service settings for reporting their services provided to patients under HCFA programs. It is also becoming used almost universally by private insurance plans. The system is updated annually by the CPT-4 Editorial Panel which meets three or four times yearly, resulting in a continuous updating mechanism. The International Classification of Diseases, 9th Revision, was expanded to meet the desires in the United States to permit greater detail in diagnostic reporting. A procedure coding scheme (Volume 3) was published as a part of the Clinical Modification. The procedure portion of the DRG process as applied by HCFA utilizes Volume 3 of ICD-9-CM in the reimbursement formula for hospital inpatient care. The World Health Organization has indicated no current plans for additional work on a taxonomy of procedures. The NCVHS adopted the position that strong efforts should be made to develop a single procedure coding system for the United States.

Meanwhile, the Subcommittee acknowledges an immediate need to update the ICD-9-CM procedure codes in view of the advances in medical technology occurring in the past decade and their importance to the Diagnosis Related Group (DRG) system, which uses the codes for determining hospital reimbursement. To address this need, an ICD-9-CM Coordination and Maintenance Committee was formed within DHHS in September 1985. This Committee is co-chaired by staff from the National Center for Health Statistics and the Health Care Financing Administration and includes members from other Federal agencies. Its highest priority will be to identify major needs for modifications, additions, or deletions to the ICD-9-CM procedure codes.

Early in the Subcommittee's deliberations, it heard from an American College of Surgeons' work group proposing to develop a "clinical entity" coding system designed to function much like a dictionary of medical terms and phrases with an automated coding of each entry (entity). While still in a planning stage, it was anticipated that the system would permit the coding of exact terms used by clinicians without the necessity for a coder ranking or interpreting them. These entity codes could then be translated into any desired classification scheme (ICD, Standard Nomenclature of Medicine (SNOMED), Current Procedural Terminology (CPT), HCFA Common Procedure Coding System (HCPCS), etc.) by utilizing a computer-bridging reference table. The American College of Surgeons is no longer continuing this activity. The Subcommittee encourages further experimentation with full text and other encoding systems by the private sector and intends to remain informed of advancements in this area.

The Subcommittee spent much time on a request made by Dr. Kerr White, a former NCVHS chairman; Dr. Jack Froom, Chairman, World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians; and Dr. Maurice Wood, Medical College of Virginia; that the ICD-10 revision process be delayed several years to enable restructuring of the classification to accommodate the International Classification of Primary Care (ICPC). They testified that the currently proposed format of the ICD-10 will not serve the needs of primary care physicians who have the vast majority of health care contacts. The staff of the World Health Organization was contacted about this issue and responded that it is not possible to delay the ICD-10 revision cycle. The official WHO policy is that the ICD-10 will include the ICPC as a member of the ICD family of classifications when accepted. The Subcommittee will follow the further development and uses of the ICPC by primary care providers in this country.

Following the adoption of the 9th Revision of the ICD, a modification, ICD-9-CM, was developed to better serve the needs of the United States in documenting diagnoses. Efforts will be made to influence the World Health Organization to adopt a 10th Revision adequate to meet the needs of the country. Should this not happen, however, a modification must be considered. If judged to be necessary, NCVHS and the Subcommittee will advise as to the planning, development, and implementation of such an activity.

In summary, it is expected that the Subcommittee on Disease Classification and Automated Coding of Medical Diagnosis will continue to serve as a forum where concerns and interests can be expressed; as a liaison between the private and governmental sectors in health statistics; as a monitor of ongoing activities; and, at times, as an arbiter and conciliator among disputants.

Statistical aspects of physician payment systems

During its meeting of May 17-18, 1984, the National Committee on Vital and Health Statistics discussed the research and pilot activities being conducted, primarily by the Health Care Financing Administration, to change the methods of physician reimbursement for ambulatory care of Medicare patients. These activities were seen as having a potential major impact on health statistics and on the comparability through time and across health care settings. With the concurrence of the Assistant Secretary for Health, the Committee Chairman appointed a small work group to gather further information and to make recommendations to the full Committee.

The Work Group obtained extensive background information on Medicare data requirements and data bases from representatives of the Health Care Financing Administration (HCFA) and reviewed current studies regarding physician services and other relevant data activities with HCFA and Public Health Service (PHS) staff. The Work Group concluded that numerous forces within the health care sector are stimulating changes with varying degrees of data dependency. Until the applicable data systems have been fully defined and stabilized, the Work Group recommended that a Subcommittee on the Statistical Aspects of Physician Payment Systems be established to provide liaison with HCFA and the PHS to address the following issues:

1. The specific needs of users of data from patient/physician encounters in ambulatory care settings via the major data bases should be more clearly defined.
2. A symbolic overview of the flow of data from various ambulatory settings into the various national data bases would be helpful in schematically relating individual activities with overall patterns.
3. The different sites of ambulatory care and the types of services delivered need to be better defined in order to promote an improved understanding of data requirements.
4. The desire to achieve uniformity of data while avoiding unnecessary duplicative effort warrants the review of the Uniform Ambulatory Medical Care Minimum Data Set in light of current needs. This reassessment should be coordinated with the NCVHS review of the Uniform Hospital Discharge Data Set and the Long Term Care Minimum Data Set to ensure comprehensiveness, minimize redundancy, and facilitate episode linkages.

During fiscal year 1985, this Subcommittee on Statistical Aspects of the Physician Payment Systems met in June and September. At the first meeting, representatives from the Medicare program, the Metropolitan Life Insurance Company, and the Blue Cross/Blue Shield Association each provided an overview of ambulatory care data flow for the patient/physician encounter in their respective organizations. Current data procedures, requirements, and problems, as well as anticipated future data needs, were discussed. The second meeting of the Subcommittee focused on the data requirements of health maintenance organizations and State Medicaid programs. Staff officers from the Group Health Association of America and the Pennsylvania Department of Public Welfare gave presentations.

The Subcommittee will continue to hear presentations from public and private insurers and other users of ambulatory care data from the patient/physician encounter in order to explore common needs, problems, and solutions. The Subcommittee intends to make a full report of its findings and recommend next steps in February 1986.

Minority health statistics

At the December 1984 NCVHS meeting a small work group was created to study the recommendations of the Secretary's Task Force on Black and Minority Health. It was expected that among the recommendations would be some requirements for the National Center for Health Statistics to provide a wide array of health statistics on minority populations. A subcommittee might be needed to review NCHS publications in terms of the provision of minority data, and may make recommendations to enhance data collection programs. The Committee approved a work group to review the Task Force report and to prepare a charge for a formal subcommittee. The Work Group on Minority Health Data met on June 27 and November 7, 1985. At the NCVHS November 1985 meeting, the Chairman of the Minority Health Data Work Group distributed the Work Group's summary of the recommendations of the Secretary's Task Force on Black and Minority Health. The Work Group's summary listed seven possible charges on which the Subcommittee could focus over a period of the next several years.

The Committee agreed to proceed with the charges and established a formal Subcommittee on Minority Health Data to replace the Work Group.

Data gaps in disease prevention and health promotion

At the December 1984 National Committee meeting a work group was established to gather information on current activities surrounding the 1990 Health Promotion Initiative (see report, "Promoting Health/Preventing Disease: Objectives for the Nation"). Various Departmental programs must measure their progress toward achieving these objectives but for many of the objectives there are no readily available data to track changes. The National Center for Health Statistics will continue to have a role in providing some of this information and it was suggested that NCVHS could assist the Center in setting priorities among competing data demands.

The Work Group on Data Gaps in Disease Prevention and Health Promotion met on March 27, June 28, and November 7, 1985. In addition, the Work Group members have attended many meetings of other organizations on this topic and have become fully informed on the activities currently in progress. The Office of Disease Prevention and Health Promotion has been performing a midcourse review on these objectives; the Association of Schools of Public Health is considering an ad hoc task force; there was a Prevention '85 conference in Atlanta; a regional effort is being pursued in New England; the Public Health Foundation (formerly the Association of State and Territorial Health Officials Foundation) is collecting data; the Institute of Medicine has some projects underway; and many other organizations have expressed an interest.

At the November 1985 meeting of the Committee a subcommittee was established to continue the work begun by the Work Group on Data Gaps in Disease Prevention and Health Promotion. The charge to the newly formed Subcommittee is being developed.

Review of the National Center for Health Statistics publications

At the May, 1984 meeting, the Committee Chairman appointed a two-person work group to examine the publications of the National Center for Health Statistics to determine how they might be made more useful to the consumer.

The Work Group on NCHS Publications Review met in August 1984 with Center staff and concentrated their efforts on the annual vital statistics volumes, which contain national data on natality, mortality, marriages, and divorces. A report containing the Work Group's recommendations was given to NCVHS in September 1984. Specific recommendations of this Work Group on the content of the vital statistics volumes were referred to NCHS for review and comment.

APPENDIX I. EVOLVING STRUCTURE AND FUNCTION OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS, 1949-85

The year 1984 marked the 35th anniversary of the National Committee on Vital and Health Statistics, which was established in 1949 by the Surgeon General of the U.S. Public Health Service. The first World Health Assembly in 1948 had recommended that member countries establish national committees to coordinate vital and health statistics activities within their countries and to serve as links to the newly founded World Health Organization's Expert Committee on Health Statistics. This recommendation was originally the idea of Dr. Halbert L. Dunn, Chief, National Office of Vital Statistics, and the head of a United States delegation to the Sixth International Conference for the Revision of the International Classification of Diseases in 1948.

The original proposal made at the World Health Assembly contained no restrictions on the membership, organizational structure, working methods, or methodologies to be used by the various national committees. About 50 countries soon developed such committees and in most of them the primary function was to coordinate the collection and compilation of vital statistics data.

Very often the new committee was really another activity of the official health agency responsible for vital statistics. However, there was nothing in the original proposal that required this, and national committees did have the opportunity to work in any area of health statistics. In 1949, the functions of the United States Committee were defined as follows:

- Delineate statistical problems of public health importance that are of national or international interest.
- Stimulate studies of such problems by other organizations and agencies whenever possible, or make investigations of such problems through subcommittees appointed for the purpose.
- Review findings submitted by other organizations and agencies or by its subcommittees, and make recommendations for national and/or international adoption.
- Cooperate with other committees or organizations concerned with public health statistics in the United States so as to serve as a clearinghouse for activities dealing with public health statistics problems.
- Serve as a link between the organizations in the United States engaged in public health statistics and the statistical secretariat of the World Health Organization, and other international agencies concerned with public health statistics.
- Cooperate with the national committees of other countries in the study of problems of mutual interest.

From its inception through 1974 the Committee was composed of 12 members selected for their technical knowledge and experience that was relevant to current Committee activities. They were appointed by the Surgeon General to staggered 4-year terms and usually met twice a year as a full Committee. Typically, there were 10 to 12 active subcommittees, each with an average membership of around seven carefully chosen experts. Each subcommittee worked on a charge framed by the parent body. Unlike current subcommittees, these groups did not necessarily include members from the parent body, although the Committee secretary usually met with them all. In addition to subcommittees, the Committee made considerable use of ad hoc groups, frequently drawn from its own

ranks, to develop proposals for further study and make recommendations on limited matters. The selection of proper areas for study and individuals to work on them was the task of the full Committee. The guiding policy through 1974 was to study technical statistical questions.

In 1974, Public Law 93-353 legislatively mandated the National Committee on Vital and Health Statistics as an advisory committee to the Secretary of what is now the Department of Health and Human Services, expanded its membership from 12 to 15 members, and defined a broad role for it in health statistics. The members are selected by the Secretary from among persons recommended from within and outside the Department who have distinguished themselves in fields such as health statistics, health planning, epidemiology, and the provision of health services.

The National Committee on Vital and Health Statistics received a new charter on November 8, 1982 (renewed in June, 1984) that incorporates the legislative mandate contained in Section 306 of the Public Health Service Act. The charter requires that an annual report be submitted to the Secretary, through the Assistant Secretary for Health, which shall contain "a list of members and their business addresses, the Committee's functions, dates and places of meetings, and a summary of Committee activities and recommendations made during the fiscal year."

The Charter specifies that this Committee shall provide advice, consultation, and assistance on the policies and plans for developing major national systems of health data collection by the Department and on the coordination of Federal health data requirements. In addition, the Committee advises on a wide range of questions in the statistical arena relating to health problems, health care resources, utilization of health care services, and health care financing and expenditures. More specifically, the Committee shall advise the Secretary on terms, definitions, classifications, guidelines, and standard means for the collection of health information and statistics.

Under changing circumstances, the Committee has been examining its roles and functions and how best to fulfill its responsibilities. The Committee has intensified its efforts to act as a forum so that diverse interests may voice their concerns about matters pertaining to health statistics. Another expanded role is to increase communication by the sponsorship of conferences, the stimulation of task forces by governmental or private agencies to study particular problems, and other similar mechanisms.

**APPENDIX II. LEGISLATIVE AUTHORITY FOR THE
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
FROM THE PUBLIC HEALTH SERVICE ACT**

Section 306 subsection (k) of Public Health Service Act

- (1) There is established in the Office of the Secretary a committee to be known as the National Committee on Vital and Health Statistics (hereinafter in the subsection, referred to as the "Committee") which shall consist of fifteen members.
- (2) (A) The members of the Committee shall be appointed by the Secretary from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. Except as provided in subparagraph (B), members of the Committee shall be appointed for terms of three years.
(B) Of the members first appointed--
 - (i) five shall be appointed for terms of one year,
 - (ii) five shall be appointed for terms of two years, and
 - (iii) five shall be appointed for terms of three years,as designated by the Secretary at the time of appointment. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of his term until his successor has taken office.
- (3) Members of the Committee shall be compensated in accordance with section 208(c).
- (4) It shall be the function of the Committee to assist and advise the Secretary--
 - (A) to delineate statistical problems bearing on health and health services which are of national or international interest;
 - (B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;
 - (C) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (i) within the Department of Health and Human Services, (ii) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans' Administration, the Department of Defense, and other Federal agencies concerned with health and health services;
 - (D) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(i);
 - (E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;
 - (F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest; and
 - (G) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems.
- (5) In carrying out health statistical activities under this part, the Secretary shall consult with, and seek the advice of, the Committee and other appropriate professional advisory groups.

APPENDIX III. CHARTER

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

PURPOSE

The Secretary is charged under Section 306 of the Public Health Service Act, as amended, 42 USC 242k, with the responsibility to collect, analyze and disseminate national statistics on vital events; the extent and nature of illness and disability of the population of the United States; the impact of illness and disability of the population on the economy of the United States, and on other aspects of the well-being of its population; environmental, social, and other health hazards; determinants of health; health resources and the supply of services by health institutions; utilization of health care; health care costs and financing; family formation, growth, and dissolution; to undertake research, demonstrations, and evaluations respecting new or improved methods for obtaining current data on the matters referred to above; to undertake epidemiological research, demonstrations, and evaluations on such matters; to provide selected technical assistance to State and local jurisdictions; to coordinate health statistical and epidemiological activities of the Department; and to engage in cooperative endeavors with other countries to foster research consultation and training programs in statistical activities.

This Committee shall provide advice, consultation, and assistance and make recommendations to the Secretary through the Assistant Secretary for Health on policies and plans in developing major national systems of health data collection in the Department, on coordination of Federal health data requirements, and on analysis over a wide range of questions relating to general health problems of the population, health care resources, the use of health care services and health care financing and expenditures. In these matters, the Committee shall consult with the Health Care Financing Administration (HCFA) and other components of the Department, other Federal entities and non-Federal organizations as appropriate.

AUTHORITY

42 USC 242k, Section 306 of the Public Health Service Act, as amended. The Committee is governed by provisions of Public Law 92-463 which sets forth standards for the formation and use of advisory committees.

FUNCTION

It shall be the function of the Committee to assist and advise the Secretary:

- (A) to delineate statistical problems bearing on health and health services which are of national or international interest;
- (B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;
- (C) to determine, approve and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use: (i) within the Department of Health and Human Services; (ii) by all programs administered or funded by the Secretary; and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans Administration, the Department of Defense, and other Federal agencies concerned with health and health services;
- (D) with respect to the design of and approval of health statistical and health information systems concerned with collection, processing, and tabulation of health statistics within the Department of Health and Human Services, and with respect to the standardized

- means for the collection of health information and statistics to be established by the Secretary under subsection (j) (1);
- (E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;
 - (F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;
 - (G) in the development of a report on the state of the Nation's health, its health services, their costs and distributions, to make proposals for improvement of the Nation's health statistics and health information systems, at such intervals as may be required by the Congress;
 - (H) in establishing standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis; and
 - (I) with respect to data on the effects of the environment on health.

STRUCTURE

The Committee shall consist of 15 members, including the Chairperson. The members of the Committee shall be appointed by the Secretary, or designee, from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. The Secretary, or designee, shall appoint the Chair for a one-year period, renewable at the discretion of the Secretary or designee.

Members shall be invited to serve for overlapping three-year terms. Terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his/her predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of his/her term until his/her successor has been appointed.

Subcommittees composed of members of the parent Committee may be established to provide the Committee with background study and proposals for consideration and action. The Chair shall appoint members from the parent Committee to the subcommittees and designate a Chair for each subcommittee. The Chair shall appoint ad hoc subcommittees, composed solely of members of the parent Committee, as necessary to address specific issues for consideration. The subcommittees shall make their recommendations to the parent Committee. Timely notification of the subcommittees and ad hoc subcommittees, including charges and membership, shall be made in writing to the Department Committee Management Officer by the Executive Secretary of the Committee.

Management and support services shall be provided by the National Center for Health Statistics, Office of the Assistant Secretary for Health.

MEETINGS

Meetings shall be held at the call of the Chair, but not less than annually, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings of the subcommittees shall be held, as necessary, at the call of the respective Chair, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all subcommittee meetings. All subcommittees shall report their findings to the Committee.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by the applicable laws and departmental regulations.

COMPENSATION

Members who are not full-time Federal employees shall be paid at the rate of \$100 per day, plus per diem and travel expenses in accordance with the Standard Government Travel Regulations.

ANNUAL COST ESTIMATE

Estimated annual cost for operating the Committee and Subcommittees, including compensation and travel expenses for members but excluding staff support, is \$126,400. Estimated annual man-years of staff support required is 2.0, at an estimated annual cost of \$66,151.

REPORTS

An annual report shall be submitted to the Secretary through the Assistant Secretary for Health, not later than December 1 of each year, which shall contain, as a minimum, a list of members and their business addresses, the Committee's functions, dates and places of meetings, and a summary of Committee activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

TERMINATION DATE

The duration of the National Committee on Vital and Health Statistics is continuing, and a new charter shall be filed no later than July 23, 1986, the date of the expiration of the next two-year period following the date of the statute establishing this advisory committee, in accordance with section 14(b)(2) of Public Law 92-463.

APPROVED

6/19/84
Date

Margaret M. Heckler
Secretary

APPENDIX IV. ROSTERS OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
Department of Health and Human Services
Office of the Assistant Secretary for Health

Roster--1983 - 1985

Robert H. Barnes, M.D. (1982-1986),
 Chairman - 1983-1986
 1014 East Blaine Street
 Seattle, Washington 98102

Mr. Cleve Killingsworth, Jr.
 (1980-1983), Chairman - 1983
 Vice President
 Group Health Cooperative
 300 Elliott Avenue West
 Seattle, Washington 98119

Mr. Theodore Allison (1983-1986)
 Vice President
 Government and Industry Relations
 Metropolitan Life Insurance Company
 One Madison Avenue
 New York, New York 10010

Carlos H. Arce, Ph.D. (1982-1985)
 Survey Research Center
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 Ann Arbor, Michigan 48106

Mr. Walter P. Bailey (1983-1986)
 Chief, Office of Cooperative Health
 and Demography
 State Budget and Control Board
 Rempert C. Dennis Bldg., Room 337
 1000 Assembly Street
 Columbia, South Carolina 29201

Elizabeth L. Barrett-Connor, M.D. (1984-1987)
 Department of Community & Family Medicine
 School of Medicine, University of
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 La Jolla, California 92093

Mr. Richard V. Bibbero (1981-1984)
 Chairman of the Board
 Bibbero Systems International, Inc.
 P. O. Drawer 7338
 Incline Village, Nevada 89450

Ronald G. Blankenbaker, M.D. (1984-1987)
 Vice President for Medical Affairs
 St. Vincent Hospital
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Irene Butter, Ph.D. (1980-1983)
 Professor of Health Planning
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 School of Public Health
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Mr. Joseph D. Carney (1982-1985)
 Manager, Center for Health Statistics
 Vital Statistics, State Health Division
 1400 S.W. Fifth Avenue
 Portland, Oregon 94720

Chin Long Chiang, Ph.D. (1981-1984)
 Chairman, Program of Biostatistics
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 University of California
 Berkeley, California 94720

Barry R. Chiswick, Ph.D. (1981-1984)
 Research Professor, Department of
 Economics and Survey Research
 University of Illinois at Chicago Circle
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William R. Felts, Jr., M.D. (1983-1986)
 Professor of Medicine
 George Washington University
 Medical Center
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 Washington, D.C. 20037

Mr. Lester R. Frankel (1982-1985)
 Executive Vice President
 Audits and Surveys, Inc.
 1 Park Avenue
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 Director, Center for Health Promotion
 Research and Development
 University of Texas Health Science Center
 Houston, Texas 77225

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 Chairman and Chief Executive Officer
 New England Medical Center, Inc.
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Suzanne S. Harris, Ph.D. (1983-1986)
 Deputy Assistant Secretary for
 Food and Consumer Services
 US Dept. of Agriculture
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Director
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Division of Epidemiology
Virginia Department of Health
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George C. Myers, Ph.D. (1985-1988)
Center for Demographic Studies
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2117 Campus Drive
Durham, North Carolina 27706

Lloyd F. Novick, M.D., M.P.H. (1985-1988)
Director
Arizona Department of Health Services
1740 West Adams Avenue, Room 407
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Nancy J. Osgood, Ph.D. (1981-1984)
Assistant Professor of Sociology
and Gerontology
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Everett Rhoades, M.D. (1980-1983)
Director, Indian Health Service
Public Health Service
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John L. Roglieri, M.D. (1981-1984)
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Fernando M. Trevino, Ph.D. (1985-1988)
American Medical Association
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Nicole Urban, Sc.D. (1980-1983)
Senior Analyst
Department of Computer Services
Virginia Mason Hospital
925 Seneca Street
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Roster--1986

Chairman

Robert H. Barnes, M.D. (1986)
1014 East Blaine Street
Seattle, Washington 98102

Lawrence W. Green, Dr.P.H. (1987)
Director, Center for Health Promotion
Research and Development
University of Texas Health Science Center
Houston, Texas 77225

Ex Officio

Manning Feinleib, M.D., Dr.P.H.
Director, National Center for Health Statistics
3700 East-West Highway
Hyattsville, Maryland 20782

Jerome H. Grossman, M.D. (1988)
Chairman and Chief Executive Officer
New England Medical Center, Inc.
Boston, Massachusetts 02111

Executive Secretary

Gail F. Fisher, Ph.D.
Associate Director for Program
Planning, Evaluation, and Coordination
National Center for Health Statistics
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Suzanne S. Harris, Ph.D. (1986)
Deputy Assistant Secretary for
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USDA
Administration Building, 207W
Washington, D.C. 20250

Current membership

(Date appointment expires.)

Mr. Theodore Allison (1986)
Vice President
Government and Industry Relations
Metropolitan Life Insurance Company
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Carmault B. Jackson, Jr., M.D. (1987)
Medical Advisor
Baptist Memorial Hospital System
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Grayson B. Miller, Jr., M.D. (1986)
Division of Epidemiology
Virginia Department of Health
109 Governor Street
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Mr. Walter P. Bailey (1986)
Chief, Office of Cooperative Health
and Demography
State Budget and Control Board
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George C. Myers, Ph.D. (1988)
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Elizabeth L. Barrett-Connor, M.D. (1987)
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La Jolla, California 92093

Lloyd F. Novick, M.D., M.P.H. (1988)
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2150 Pennsylvania Ave., NW, Rm. 405-C
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Fernando M. Trevino, Ph.D. (1988)
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Meeting Dates

All Committee meetings held in Washington, D.C.

February 24-25, 1983	May 17-18, 1984
June 13-14, 1983	September 19-20, 1984
August 21, 1983	December 13-14, 1984
December 8-9, 1983	March 27-28, 1985
February 27-28, 1984	June 27-28, 1985
	November 7-8, 1985

APPENDIX V. WORK GROUP AND SUBCOMMITTEES OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

Work Group on Policy and Direction

Roster

George C. Myers, Ph.D. (1985-1988), Chairman
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Mr. Walter P. Bailey (1983-1986)
Chief, Office of Cooperative Health
and Demography
State Budget and Control Board
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Professor of Medicine
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Center
2150 Pennsylvania Ave., NW, Rm. 405-C
Washington, D.C. 20037

Staff

Gail Fisher, PH.D., NCHS
Jack Anderson, NCHS

Meeting Date

Meeting held in Washington, D.C.

September 27, 1985

Subcommittee on Uniform Minimum Health Data Sets

Roster

William J. Scanlon, Ph.D. (1985-1988),
Chairman 1985
Co-Director
Center for Health Policy Studies
Dept. of Community/Family Medicine
Georgetown University School of Medicine
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Mr. Lester R. Frankel (1982-1985),
Chairman 1983-1985
Executive Vice President
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Suzanne S. Harris, Ph.D. (1983-1986)
Assistant Professor, Department of
Nutrition Sciences and
Investigator, Institute of Dental Research
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Assistant Professor of Sociology
and Gerontology
Medical College of Virginia
1010 E. Marshall Street
Richmond, Virginia 23298

Staff

Henry Mount, NCHS
Edward Bacon, Ph.D., NCHS
Joan Van Nostrand, NCHS

Charge to Subcommittee on Uniform Minimum Health Data Sets, June 13, 1983

Section 306(j) of the Public Health Service Act states: "The Secretary shall coordinate health statistical and epidemiological activities of the Department of Health and Human Services by:

- (1) establishing standardized means for the collection of health information and statistics under laws administered by the Secretary;
- (2) developing, in consultation with the National Committee on Vital and Health Statistics, and maintaining the minimum sets of data needed on a continuing basis to fulfill the collection requirements of subsection (b)(1);
- (3) after consultation with the National Committee on Vital and Health Statistics, establishing standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis;
- (4) in the case of proposed health data collections of the Department which are required to be reviewed by the Director of the Office of Management and Budget under section 3509 of title 44, United States Code, reviewing such proposed collections to determine whether they conform with the minimum sets of data and the standards promulgated pursuant to paragraphs (2) and (3), and if any such proposed collection is found not to be in conformance, by taking such action as may be necessary to assure that it will conform to such sets of data and standards, and
- (5) periodically reviewing ongoing health data collections of the Department, subject to review under such section 3509, to determine if the collections are being conducted in accordance with the minimum sets of data and the standards promulgated pursuant to paragraphs (2) and (3) and, if any such collection is found not to be in conformance, by taking such action as may be necessary to assure that the collection will conform to such sets of data and standards not later than the nineteenth day after the date of the completion of the review of the collection.

Since 1969, the Department has been working on the development and promulgation of uniform minimum health data sets and has made important progress, particularly in the area of the Uniform Hospital Discharge Data Set (UHDDS). The recently established Health Information Policy Council (HIPC) chaired by the Assistant Secretary for Health is, by Secretarial charter, the new focal point for these efforts within the Department. The Council has made some decisions regarding the next steps to be taken on Uniform Minimum Health Data Sets and requests the assistance and recommendations of the NCVHS in several areas. The charge reflects the specific requests made by the HIPC.

It shall be the charge to this Subcommittee to:

1. Review and evaluate the current Uniform Hospital Discharge light of current developments and identified problems. (This is a version approved by a former Secretary and another one published by the NCVHS). This review is to be conducted in cooperation with an Interagency Task Force comprised of representatives of Departmental programs which would be affected by changes in the data set.
2. Identify specific problems or inadequacies in the UHDDS coverage of items, item content, and definitions. Recommend additions, deletions, and modifications to the data set.
3. Consider current trends in data collection and storage practices within the hospital, and recommend ways and means of collection and recording the UHDDS so that it is readily retrievable.
4. Prepare a written report of the review and recommendations for submission to the HIPC by September 1, 1983.
5. Review and evaluate the current Long-Term Care Minimum Data Set (LTCMDS) in terms of the findings and recommendations of the first test and in light of identified needs.

This review is to be conducted in cooperation with an Interagency Task Force comprised of representatives of Departmental programs which would be affected by the data set.

6. Identify specific problems or inadequacies in the LTCMDS coverage of items, item content, and definitions. Recommend additions, deletions, and modifications to the data set.
7. Consider current trends in data collection and storage practices within long-term care facilities and recommend ways and means of collecting and recording the LTCMDS so that it is readily retrievable.
8. Prepare a written report of the review and recommendations for submission to the HIPC.

Meetings

All Subcommittee meetings held in Washington, D.C.

Dates

July 27-28, 1983

November 4, 1983

December 6-7, 1983

April 30 - May 1, 1984

September 17-18, 1984

March 28, 1985

Mr. William M. Perry
Bureau of Health Planning and Development

Mrs. Purlaine Lieberman
Health Insurance Association of America

Ms. Patricia McGuire
American Medical Association

Mr. James Lee
Blue Cross/Blue Shield Association

Mr. Edward L. Perrine
Florida Gulf Health Systems Agency

Invited Speakers

Dr. Benjamin C. Duggar
JRB Associates

Mr. James P. Cooney, Jr.
Duke University Medical Center

Ms. Mary E. Converse
American Hospital Association

Ms. Jean Chenoweth
Commission on Professional and
Hospital Activities

Ms. Rita Finnegan
American Medical Records Association

Ms. Cleo Kalonick
American Association of Health Data Systems

Ms. Jolane M. Huber
McAuto Health Service

Mr. Howard West
Mandex

Mr. Paul Farseth
Minnesota Medicaid

Mr. William Mahon
South Carolina Medical Care Foundation

Dr. Robert Ludke
University of Iowa

Mr. Walter P. Bailey
South Carolina State Budget and Control
Board

Ms. Jill Callahan
American Medical Records Association

Dr. James W. Thompson
National Institute for Mental Health

Mr. Stephen F. Kaufman
Indian Health Service

Mr. Paul Quinn
Suburban Hospital
Bethesda, MD.

Dr. Ethel Shanas
Evanston, IL

Mr. Theodore D. Woolsey
Bethesda, MD

Ms. Anne A. Scitovsky
Palo Alto Medical Research Institute

Dr. Allen Dobson
Health Care Financing Administration

Dr. Sidney Katz
Brown University

Barbara Lowell, R.N.
Manor Healthcare Corporation

Dr. Barry Gurland
Columbia University

Mr. David Riland
Manor Healthcare Corporation

Subcommittee on the Vital Statistics Cooperative Program

Roster

Mr. William L. Kempiners
(1982-1985), Chairman
Director, Illinois Department of Public Health
535 W. Jefferson Street
Springfield, Illinois 62761

Everett Rhoades, M.D. (1980-1983)
Director, Indian Health Service
Public Health Service
5600 Fishers Lane, Room 5A-55
Rockville, Maryland 20857

Mr. Joseph D. Carney (1982-1985)
Manager, Center for Health Statistics
Vital Statistics, State Health Division
1400 S.W. Fifth Avenue
Portland, Oregon 94720

Chin Long Chiang, Ph.D. (1981-1984)
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Charge to Subcommittee on the Vital Statistics Cooperative Program, June 10, 1983

The vital registration and statistics system in the United States is a long-standing, State operated and controlled program based on State statistics. Since 1902, the Bureau of the Census and the National Office of Vital Statistics, now the National Center for Health Statistics (NCHS), have compiled national mortality statistics by obtaining copies of death records from the vital statistics offices of States and cities with adequate death registration systems. A similar system for reporting national birth registrations was begun in 1915 and for marriage and divorce registration in 1957 and 1958. Reporting of induced termination of pregnancy or abortions was initiated by NCHS in 1977. NCHS and its predecessor agencies have played an integral part in the development of the vital registration and statistics system in the United States. In 1974 NCHS implementation of the Vital Statistics Cooperative Program (VSCP) significantly increased the Federal participation in these developmental activities by increasing the Federal payment from 4 cents per record to a major level of financial support for these systems. The concept was that stability of funding to the States through the VSCP would encourage the comparability, uniformity, accuracy, and completeness of registration needed for both a high quality and low cost nonduplicative reporting system for use by the public and private users at the Federal, State, and local levels. Questions have arisen in implementing the concepts around shared activities and shared funding. The primary problem currently is that the system has not been uniformly implemented on all data sets in all registration areas. An important consideration is agreement on the appropriate share of costs to be borne by participants in the system, consideration also needs to be given to the basic concepts of the system such as the responsibilities and rights of the partners, what products will be available at different geographic levels, and who has access to these products or data and at what cost.

In light of changing perspectives, Federal/State relationships and economic conditions, reasonable assumptions must be established and agreed to with respect to the future scope of the vital statistics program and mechanisms established for appropriate support of the system.

It shall be the charge to this subcommittee to:

1. Review background and basic concepts of shared activities in light of the changing roles of and relationships between Federal and State governments.

2. Examine Federal, State, and private requirements, responsibilities, rights, and commitments to systems design, operation, and management.
3. Provide an assessment of the current status of the VSCP and the potential for funding the system. With respect to funding, consideration must be given to the "Report of the Completion of the Vital Statistics Cooperative Program," Federal/State responsibilities for the system, users fees, and the critical economic shortages at the Federal and State levels.
4. Make recommendations for the future including programmatic and funding considerations.

Meetings

All Subcommittee meetings held in Washington, D.C.

Dates

August 21, 1983

February 14-15, 1984

Mr. Donald E. Starsinic
Bureau of the Census

Dr. Gilbert Beebe
National Cancer Institute
National Institutes of Health

Invited Speakers

Mr. Frederick L. King
Minnesota Department of Health

Ms. Mary Anne Freedman
Vermont Department of Health

Dr. Patricia W. Potrzebowski
Pennsylvania Department of Health

Mr. Merle L. Shields
California Department of Health Services

Ms. Helen Cesari
Alcohol, Drug Abuse
and Mental Health Administration

Mr. Gerry Hendershot
Office of Population Affairs
Office of the Assistant Secretary for Health

Mr. John Wilkens
Social Security Administration

Dr. Samuel Kessel
Division of Maternal and Child Health
Health Resources and Services
Administration

Mr. Aaron Handler
Indian Health Service
Health Resources and Services
Administration

Mr. Jack C. Smith
Centers for Disease Control

Mr. Todd M. Frazier
National Institute for Occupational
Safety and Health
Centers for Disease Control

Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses

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Sue Meads, NCHS
Harry Savitt, M.P.H., P.D., HCFA

Charge to the Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses, June 10, 1983

A number of computer systems are being developed in the United States for the purpose of converting medical diagnoses into numeric codes. At the same time, there is continued improvement in the automation of medical records in hospitals and physicians offices and the submission of claims and bills on computer tapes. These automated records include codes for the medical conditions.

A more recent development is payment plans based on Diagnostic Related Groups (DRG) where patients are grouped based on the nature, complexity, and treatment resources required. Rates are set for each different DRG and hospitals are paid on the basis of the DRG of each patient. This method has increased the use of the International Classification of Diseases (ICD) coding within the hospitals.

A third related topic is the expected revision of ICD-9 which could impact on both automated medical coding systems and DRG methodology. The World Health Organization has been responsible for the periodic revisions of the ICD since 1946. Requirements for increased collection, processing, and computerization of medical care records, particularly in hospitals in the U.S., precipitated the first adaptations of the ICD for clinical use with the eighth revision. The need for such adaptation has continued to the present time. Prior to the next revision of the ICD, consideration must be given to the utility of the ICD and the historic adaptations for varied purposes and the alternatives for the future.

The interrelations among these developments are complex and can appear confusing. There is a need to sort out these interrelationships and to determine where there must be close coordination and where independent development can proceed.

It shall be the charge to this Subcommittee to:

1. Review the current status of the International Classification of Diseases, Diagnostic Related Groups and claims processing, and automated coding of medical diagnoses.
2. Identify those areas where the above three developments must work in close cooperation and, on the other hand, those areas where developments can proceed relatively independently, for example, medical terminology and nomenclature and its relationship to numerical coding in computer systems.
3. In those areas where close cooperation is necessary, identify apparent issues and problems that require resolution.
4. Explore alternative methods for resolving the problems and issues identified in (3) above and a time frame for accomplishment.
5. Report to the Committee on findings, recommendations for resolving issues and problems, and suggested courses of action.

Meetings

All Subcommittee meetings held in Washington, D.C.

Dates

July 14-15, 1983

Mr. Charles Rothwell
North Carolina State Center for
Health Statistics

November 7-8, 1983

Dr. Virgil Slee
Private Consultant

May 17, 1984

Mr. Philip Latessa
American Association of Health Data
Systems

July 11-12, 1984

November 27-28, 1984

Ms. Rita Finnegan
American Medical Records Association

March 25, 1985

Dr. Leonard T. Kurland
Mayo Clinic

Invited Speakers

Dr. Harold A. Zintel
American College of Surgeons

Dr. Peyton Weary
University of Virginia Medical Center

Ms. Mary E. Converse
American Hospital Association

Dr. Lawrence E. Rosenthal
American Academy of Dermatology

Ms. Patricia A. McGuire
American Medical Association

Dr. Robert Spitzer
New York State Psychiatric Institute

Dr. David J. Rothwell
College of American Pathologists

Dr. Jack Froom
Stony Brook, N.Y.

Mr. Garland Land
Missouri State Center for Health Statistics

Dr. Linda Demlo
University of Iowa

Ms. Jean Chenoweth
Commission on Professional and
Hospital Activities

Ms. Purlaine Lieberman
Health Insurance Association of America

Dr. Kerr White
Private Consultant

Ms. Mary-Josita Reding
Brooks Air Force Base, Texas
Department of the Air Force

Ms. Monica Wilkins
Veterans Administration

Ms. Muriel Brandford
Department of the Navy

Ms. Erna Jantzen
Department of the Army

Subcommittee on Statistical Aspects of Physician Payment Systems

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Charge to Subcommittee on Statistical Aspects of Physician Payment Systems

- Determine more clearly the specific needs of users of data from patient-physician encounters in the ambulatory care setting.
- Develop a schematic overview of the flow of data from various ambulatory settings into the various data bases.
- Define better the different sites of care in the ambulatory setting and the types of services delivered so that understanding of data requirements can be improved.

The results of these tasks will be input into the possible review of the Minimum Data Set for Uniform Ambulatory Medical Care.

Meetings

All Subcommittee meetings held in Washington, D.C.

Dates

June 14, 1984

July 11, 1984

October 22, 1984

June 19, 1985

September 10, 1985

October 15, 1985

Invited Speakers

David Zimmerman
Metropolitan Life Insurance Company

Mr. David Rinaldo
Metropolitan Life Insurance Company

Mr. Steven Culler
Blue Cross and Blue Shield Association

David Plotnick
Group Health Association of America

Gerald Radke
Pennsylvania Department of Health

Proposed Subcommittee on Minority Health Data

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Proposed Charge to Subcommittee on Minority Health Statistics

In January 1984, the Secretary of Health and Human Services established a Secretarial Task Force on Black and Minority Health to conduct a comprehensive investigation of the health problems of Blacks, Native Americans, Hispanics, and Asian/Pacific Islanders given the continuing disparity in the health status of minorities and the nation's population as a whole. The Task Force, composed of 18 senior scientists and officials drawn from throughout the Department, conducted an exhaustive investigation which was detailed in their seven volume report. Of the eight recommendations made to the Secretary, two recommendations focused on the need for data on minority populations.

"The Task Force believes that data issues are a major area for recommendations and suggests that more extensive minority health and illness data are needed to improve the information available to DHHS and the private sector for making program and policy decisions. Examples of why this is so include:

- National data on mortality rates for Hispanics are lacking.
- The accuracy with which ethnic group membership is described on death certificates, especially for Hispanics, is variable.
- Studies based on diabetes mortality rates in minorities fail to consider differences in incidence, age of onset, availability of medical care, education, socioeconomic status, and interaction with hypertension.
- Population-based cancer registries often lack comparability with information from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program.
- The incidence of sudden cardiac death in Blacks in relationship to coronary heart disease has been examined, but no firm conclusion is possible because of lack of data.

Reliable data are central to measuring progress in public health, and are the key to assessing the current health status of the Nation and measuring health status trends; recognizing both sources of and solutions to problems; identifying health disparities between segments of the population; and targeting efforts directly to specific needs.

The data available in the Task Force review and other reports have pointed to disparities in death rates, health status, and health care utilization between minorities and nonminorities, but more detailed data are needed to enhance our understanding of the processes underlying the disparity and to provide a better basis for rational program planning, implementing, and monitoring. The effort to obtain reliable data is especially challenging because minority populations are growing rapidly, changing rapidly, highly mobile, and, therefore, difficult to track yet have greater health problems than nonminorities.

RECOMMENDATION 7: IMPROVING AND FULLY USING AVAILABLE SOURCES OF DATA

DHHS should undertake activities, which would improve existing sources of health data, such as: enhancing cooperative efforts with the States in recording vital statistics, incorporating specific racial/ethnic identifiers in data bases, and oversampling selected minorities in national surveys. Furthermore, DHHS should support innovative uses of currently available data consistent with the Privacy Act and confidentiality constraints. Analyses such as cross-comparisons from different data sets and specialized studies should be encouraged because they can contribute to understanding the health status and needs of minority populations.

RECOMMENDATION 8: RESEARCH AGENDA

The Department should adopt and foster a research agenda to investigate factors affecting minority health and should incorporate appropriate research activities on minority health into ongoing research programs consistent with the referral guidelines of each DHHS agency. The Task Force considers the following areas to be of major importance for research:

- Risk factor identification
- Risk factor prevalence
- Health education interventions
- Preventive services interventions
- Treatment services
- Sociocultural factors and health outcomes."

It shall be the charge to this Subcommittee to:

1. Review the cooperative efforts between DHHS and the States directed at developing standardized Hispanic identifiers in vital statistics records.
2. Review the cooperative efforts to train personnel to complete vital statistics records accurately (particularly with regard to correct coding of causes of death and racial/ethnic identifying items).
3. Assess compliance with the Office of Federal Statistical Policy and Standards Directive Number 15 among DHHS agencies that collect health data. Where possible and desirable, further breakdown within racial and ethnic categories should be encouraged, e.g., national origin of Hispanics and Asian/Pacific Islanders. Also, agencies should be encouraged to maintain specific racial/ethnic identifiers when processing original data.
4. Explore mechanisms for matching individual records from among government data sets for health and statistical research purposes.
5. Review current and planned DHHS data collection systems, assess their ability to produce data on minorities, and make appropriate recommendations.
6. Review the efforts of on-going research programs to incorporate appropriate research activities on minority health.
7. Report to the Committee on findings, recommendations for resolving issues and problems, and suggested courses of action.

Proposed Subcommittee on Data Gaps in Disease Prevention and Health Promotion

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Proposed Charge for Subcommittee on Data Gaps in Disease Prevention and Health Promotion

This Subcommittee was created by unanimous vote of the National Committee on Vital and Health Statistics (NCVHS) on November 7, 1985, recognizing the high priority accorded policy and new programs in these fields and the relatively underdeveloped national data systems and standards to support planning, management and evaluation of such programs. Dr. Feinleib has agreed to assign Mr. Ronald Wilson as the staff liaison of NCHS for the Subcommittee.

The broad mission of the Subcommittee will be to assess the appropriateness and adequacy of available data systems (record-based data aggregated at a national level, and surveys with established periodicity on samples that can be generalized to the national population or can provide reliable indicators of national progress) on disease prevention and health promotion, as defined by the Surgeon General's initiative and PL94-317.

- Appropriateness will be assessed against the coverage of Objectives for the Nation in disease prevention and health promotion for 1990 (USDHHS), and for the year 2000 (WHO, and in preparation by DHHS agencies).
- Adequacy will be assessed on the basis of criteria including but not necessarily limited to:
 - accessibility of the data to potential users
 - statistical quality, based on sampling design and data collection procedures
 - measurement quality, based on reliability and validity considerations, and on confidentiality considerations.

A previous analysis of data gaps in disease prevention and health promotion (Green, Wilson and Bauer, *AJPH*, 1983) found that most of the data gaps in relation to the 1990 Objectives for the Nation were in relation to the health promotion objectives, rather than the health protection (environment) and preventive health services objectives. It is proposed, therefore, that the starting point for the Subcommittee review should be on health promotion.

- Participate, as NCVHS representatives, in meetings of other groups scheduled to convene during the APHA convention in November, to identify more currently how the Subcommittee can best use and supplement the efforts of other organizations addressing data gaps in disease prevention and health promotion.

- Compile inventory of data sources and data items related to each of the health promotion objectives.
- Recommend NCVHS role in supporting the development, maintenance, improvement and quality control of data systems for health promotion.
- Recommend other Federal action to fill gaps and to strengthen the quality of data available for policy decisions in health promotion.

Work Group on NCHS Publications Review

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Meeting

Meeting held in Hyattsville, Md.

August 20, 1984

FILE