DataSpeak
Findings from the 2011-2012 National Survey of Children's Health
Transcript
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Michael Kogan, PhD – Maternal and Child Health Bureau – Director, Office of Epidemiology and Research
Good afternoon and welcome to today's DataSpeak web conference on the newly released findings from 2011 and 2012 National Survey of Children's Health. I'm Michael Kogan, and I'm the Director of the Office of Epidemiology and Research at the Maternal and Child Health Bureau. We're excited to have with us today three speakers to discuss the purpose of the survey, its methodology and key findings and ways to access the new data. Our first presenter today will be Dr. Stephen Blumberg. He is the Associate Director for Science in the Division of Health Interview Statistics at the National Center for Health Statistics, which is part of the CDC. He will begin discussion by describing the content of the survey including methods used to collect data, response rates, and differences in design between versions of the survey. I will serve as the second presenter today and I'll be discussing potential uses for the survey as well as highlighting some national and state-level findings. Finally, Dr. Christina Bethell, founding director of the Child and Adolescent Health Measurement Initiative will discuss how to access results of the survey through the MCHB-supported Data Research Center for Child and Adolescent Health. Now, before we begin, I would like to introduce Sarah Lifsey, the moderator for today's program. Sarah.

Sarah Lifsey – Altarum Institute – Policy Associate
Thank you. First, I'd like to welcome our presenters and everyone who is in the audience today. Thank you all for joining us. Before we begin our presentation, I just have some brief technical guidance for you all. First, I'd like to call your attention to the DataSpeak website, which we hope you'll visit after today's program. On the website, you will find archives of all the DataSpeak programs going back to 2000. The slide on your screen shows some of the most recent programs that are available and the address you can use to access them. I'd also like to point out that you are able to download today's PowerPoint presentations directly from the screen that you are seeing right now. Click on the presentation that you are interested to highlight it, click save to my computer and follow the simple instructions on the screen. If you would like to make the slides larger, simply press the full screen button at the top of the screen and to return to the original view, press it again.
I'd also like to point out that the Data Resource Center for Child and Adolescent Health is hosting a live twitter chat related to this webinar. You can join it using the hash tag #NSCHchat and you can also post questions there. Finally, please know that your phone line will be muted during the presentations. At the completion of the program, we'll be having a question-and-answer session and we will provide instructions for asking questions over the telephone at that time. If you'd like to post a question online, you can do so at any time during the program. Using the questions box at the bottom of the screen, simply type your question in the box next of the arrow and hit enter. Now I would like to turn to the first speaker, Dr. Stephen Blumberg. Dr. Blumberg.

Stephen Blumberg – National Center for Health Statistics, Centers for Disease Control and Prevention – Associate Director for Science, Division of Health Interview Statistics
Thank you Sarah. My role here today is to tell you a little bit about the National Survey of Children's Health and how it was conducted in 2011 and 2012. And then I'll be followed by the presentation on the findings that I'm sure you're much more interested in. Nevertheless, the National Survey of Children's Health is sponsored by the Maternal and Child Health Bureau and has been conducted three times to produce national and state-based estimates on the health and well-being of children, their families and their communities. Now, it was repeated in 2011-12 in order to assess changes in the health and well-

being of children in the past decade. But as we've done back in 2007, some questions were modified in order to address specific needs of Maternal and Child Health Bureau and in 2011-12, their interest was to adapt the survey, at least somewhat, to reflect the life course perspective on children's health. As such, we now have questions in the survey on whether or not the child was born prematurely, we ask about the age of first diagnosis for selected conditions. We have an expanded section on flourishing, so for younger children we ask about the extent to which they're affectionate or resilient, curious or laughs a lot.

For older children, we ask about the extent to which they're able to finish tasks that they start or the extent to which they stay calm and in control when faced with challenges. There was also a question added about adult mentoring, whether children have…older children have an adult mentor who they can rely on for advice or guidance. We've got questions about the parents and grandparents education, as well as some new questions about adverse family experiences, such as whether anyone in the child's immediate family was ever divorced, died, spent time in jail or the child experienced violence in the home or whether any parents had mental illness or drug related problems, and the like.

The National Survey of Children's Health is part of the State and Local Area Integrated Telephone surveying mechanism, or SLAITS, and that mechanism has been used to conduct a number of surveys regarding children and their health, healthcare access utilization, starting with the National Survey of Early Childhood Health back in 2000. Many of you on the line, however, are familiar most with the National Survey of Children with Special Healthcare Needs, which has been conducted three times, starting in 2001. It also has been used for follow-up or follow-back surveys such as the National Survey of Adoptive Parents, which followed back the National Survey of Children's Health from 2007. And I'll tell you a little bit, towards the end of the presentation, about the National Survey of Children in Nonparental Care, which will be a follow back of children from the 2011-2012 National Survey of Children's Health.

The interview process for 2011 and 2012 was similar to previous years. We have independent random-digit-dial samples in all 50 states, plus the District of Columbia. The one thing that's different for 2011 and 2012 is that we now include cell phone numbers as part of those random-digit-dial samples. Once we dial a phone number and find out whether or not it belongs to a household, if it does belong to a household, we screen those households for children under the age of 18, and if there are children under 18 years of age, one is randomly selected to be the target of the interview. The interview itself lasted on average about 33 minutes. The respondent was usually the mother, but we asked for a parent or guardian who was knowledgeable about the health of the child and in about one out of four cases that was a father. In 7% of the cases, it was another relative or guardian.

Interviews were conducted in English, Spanish and four Asian languages that was Mandarin, Cantonese, Korean and Vietnamese. About 5% of the interviews completed in Spanish, it's less than 1%, if I recall, completed in the Asian languages. We did offer cash incentives to increase response rates and convince some households with children to participate in the survey, and about 20% of the interviews were completed after we had offered this incentive.

Now, the data files are weighted. Sampling weights permit national and state specific estimates of health and well-being. These sampling weights are adjusted for potential nonresponse bias, and to account for the non-coverage of non-telephone households, but only about 2% of children live in households that have no phones whatsoever. And as noted here in the slide, these adjustments are applied separately for landline and cell phone samples, because the nonresponse characteristics are different for the two samples. Once we combined the two samples, then the weights are further adjusted to match Census Bureau population totals for various demographic groups, ultimately yielding a data set where when the weights are used, the estimate estimates are representative of the non-institutionalized population of children in the United States and in each state.

We collected the data from roughly the end of February through June of 2012, February of 2011 I should say, and the midpoint of data collection was the end of September 2011. Over 95,000 interviews were completed. The goal was at least 1,800 interviews per state, and we achieved that in every state, the smallest sample size being in South Dakota and a maximum sample size, which is 2,200 in Texas. The overall response rate was 23%, ranging from 19.5% in California to 34% in Montana and Wyoming. But I want to say a little something more about response rates. When we talk about this 23 % response rate that really is the most conservative response rate that we could possibly report. It is a combination of three other rates. Those are the resolution rate, the screener completion rate and the interview completion rate. The resolution rate is the percentage of numbers that we could determine definitively belonged either to a household or not to a household. When numbers ring with no answer, those numbers are obviously not resolved. Once we reach a household, the screener completion rate reflects the percentage of households where we were able to find out whether or not a child lived in that household, and then the interview completion rate reflects the percentage of households with children, that we know have children, where we were able to complete an interview.

You can see that that 23% is a combination of the landline and cell phone sample, but really is low because of the cell phone sample and…the response rates for the cell phone samples. All of the various component rates are lower for the cell phone sample than for the landline sample, but you can see that the biggest difference is with the resolution rate, that is, it's not a reflection of households not willing to talk to us on cell phones, but rather that when we're dialing cell phones, many more of them ring with no answer or ultimately we're unable to determine, based on whatever messages the phone system sends back, we're unable to determine whether it's working, nonworking, a household or not a household.

Certainly, when you've got a response rate as low as 23%, it makes sense to investigate whether there's nonresponse bias. We do note that the interviewed population is more likely to live in rural areas, also more likely to live in areas where there's a higher proportion of homeownership, lower home values and a greater percentage of non-Hispanic white persons. But all of these characteristics are included in the adjustments that we make to the weights for nonresponse and ultimately for waking. As a result, these weighting adjustments reduce the magnitude of bias that might be associated with this differential response and we find when we've look at various key variables out of the survey, the maximum bias that we can detect is on the order of just about one percentage point, so in other words, plus or minus one percentage point. And in every case, that maximum bias is less than the potential sampling error, that is, if we took the sampling error plus or minus plus two or three, generally we find the bias associated with nonresponse is smaller than the potential sampling error.

Moving on now to the content of the survey you see the survey domains generally look at child characteristics, family level influences and neighborhood and community influences. Essentially the goal of the survey is to address the extent to which children, we have healthy children, healthy family and healthy communities. When we talk about health and functional status of the child, we have questions obviously about their general health status, height and weight for adolescents, BMI calculation there, the CSHCN screener. We ask about the prevalence of specific health conditions, the severity of those conditions and we have questions about the risk of developmental delay using the PEDS scale, the parent's evaluation of developmental status. We have a number questions about health insurance coverage and healthcare utilization, including whether or not the child was covered currently or at the time of the interview I should say, covered in the past year. But as well, whether that insurance is adequate to meet the child's needs. We asked about utilization of several different types of healthcare services including some new questions on vision testing and home visitation programs. We have questions about medical home that is the AAP definition of a healthcare system that is coordinated, comprehensive, family centered. A number of questions that are specific to the age of the child, from childcare attendance and

breast-feeding for younger children, to school attendance and engagement, sleep, exercise, working, working for pay, time spent in front of a screen for older children.

Then we get to the sections about the family where we ask about whether they share meals together, attend religious services, how close the parent feels to the child, parental aggravation with the parenting role and how well parents are coping with that. A few questions about parent's general health status and mental health status as well as smoking in the household. And then for neighborhood characteristics we ask about neighborhood cohesion, some of the physical condition of the neighborhood, you know, the negative side as well is the positive side, looking at amenities such as parks and playgrounds and libraries. We also asked parents whether they feel that their child a safe in the community and in school. And of course, we also have a host of demographics on the survey.

I did say was going to mention the National Survey of Children in Nonparental Care. This is a survey that is going to be linkable to the National Survey of Children's Health. It is a follow back survey of roughly 1600 children from not NSCH, who are not living with biological or adoptive parents. Most of these children are living with grandparents or with foster parents, in some cases, it's other relatives other than parents and the survey is asking these caregivers about their well-being and their access to and utilization of various services and support.

And here's my contact information. I've listed there the website for the NSCH, where you can find more information about the methods, as well as data files if you're interested in trying to analyze the micro data. If you've got any questions, we'll certainly answer them at the end of this webinar, but also you can contact us, either myself at my email address, or generally SLAITS@CSC.gov. Thank you.

<u>Sarah Lifsey – Altarum Institute – Policy Associate</u>
Great, thank you so much. As a reminder, if you have a question for our speakers, you can submit it online at any time using the form, the Q&A questions form on the bottom of your screen. So, I'd like to turn to our next speaker, Dr. Michael Kogan. Dr. Kogan.

<u>Michael Kogan, PhD – Maternal and Child Health Bureau – Director, Office of Epidemiology and Research</u>
Thank you, Sarah. And I'm going to talk about findings from the national survey. As you heard from Stephen's presentation, there are a lot of different sections, so what I'm hoping to do is touch on a number of the key findings in a variety of areas. Next slide please. The – as Stephen mentioned, this is the third iteration of the National Survey and we know this survey can be used in a number of different ways. It's been used by every state for Title V needs assessment, it's been used probably by every state for planning and program development at the state level and now you can look at changes over the past decade for children's health and literally hundreds of papers have been published on the surveys already. Next slide.

Let me begin by talking about parent-reported child's health status. Over 84% of parents reported that their child was an excellent or very good health while 71.3% of parents reported that their child had excellent or very good oral health. There were no statistically significant changes compared to the 2007 National Survey. Next. In terms of prevalence of conditions, we asked about a number of chronic conditions including questions on whether a healthcare provider ever told you that your child has this condition and if so, whether you're child currently had the condition. These numbers are based on whether the child currently had the condition. ADD, ADHD has increased significantly. In 2011-12, it was 7.9%; in 2007, it was 6.4%. The prevalence of speech problems also increased. In 2011-12, it was 4.8%; in 2007, it was 3.7%. Finally, the prevalence of anxiety problems increased significantly. It was 3.4% in 2011-2012 and that was significantly higher than estimate of 2.9% in 2007. Next. The prevalence of autism spectrum disorder in 2011-2012 was 1.88% compared to 1.1% in 2007.

Next. Turning to health insurance coverage, there have been changes since 2007. First, the percent of children uninsured has declined. The prevalence in 2011-12 was 5.6% compared to 9.2% in 2007. The percent of children receiving public insurance increased in 2011-12, 37.1% receive public insurance compared to 29% in 2007. Moreover, the percent of children with a gap in their coverage declined. The prevalence was 11.3% in 2011-12 and in 2007, it was 15.1%. Next please. Here are the comparisons since the first National Survey of Children's Health, and you can see the shift from private to public insurance over time. Next. Looking at state variation, the percent of children insured at the time of the survey range from 99% in Massachusetts to 86.7% in Nevada. There have been major improvements in states, with the lowest prevalence of insured children since 2007. Nevada's prevalence estimate in 2007 was 80.6%. Texas' estimate in 2011-12, as you see here, was 90.6% and that's compared to 82.9% in 2007. Likewise, Arizona's estimate was 88.3% in 2011-12 and 83.8% in 2007.

Next. As Dr. Blumberg mentioned, we also measure adequacy of health insurance for all these children reported to be currently insured. Insurance was considered adequate if the parents reported that the child's health insurance usually or always met all three of the listed criteria. What we found that among currently insured children, a little over three quarters were considered to be adequately insured and these figures are unchanged from 2007. Next please. This slide shows that 84% of children were reported to receive a preventive visit in the last year and 77% received preventive dental care. These figures cannot be compared to 2007 because of a change in the question wording. Next. However, they can be compared to 2003 and we see there has been a significant increase in the estimate of children who have received a preventive medical visit, going from 77.8% to 84.4%. Next please. This slide shows that among children reported by their parents to have emotional, developmental or behavioral problems, only 61% received mental health services in the past year. Now this is essentially unchanged from 2007 when the prevalence was 60%.

Next, looking at medical home now. Medical home is an algorithm based on five components, whether the child had a personal doctor or nurse, a usual source of care, whether they received family centered care, whether they received any needed referrals and whether they received care coordination when needed. Using this algorithm, we found that 54% of children were reported to have had a medical home, which was a significant decline from 2007 when it was 57.5%. Next please. Well we have good news on breast-feeding; the prevalence of children ages birth to five who were ever breast-fed was 79.2% in 2011-12, representing a significant increase from 2007 when it was 75.5%. Further, the percent of children exclusively breast-fed was 16% in 2011-12, again representing a significant increase from the 12.4% in 2007. Next please. There were very wide state variations in the prevalence of breast feeding, ranging from 92% in Oregon to 57.7% in Mississippi. However, there have been marked improvements in states with the lowest prevalence estimates. For example, in 2003, the lowest state prevalence was 45%, in 2007; the lowest prevalence estimate was 52.7%.

Next – this was the first year that we collected information on premature birth, as Dr. Blumberg mentioned, and we found that 11.6% of children were reported to have been born more than three weeks before his or her due date. In addition, 7.9% reported to have been born low birth weight, which was not significantly different from 2007. Next please. We looked at the use of electronic devices not used for schoolwork and found that over 11% of children spent more than four hours per weekday using electronic devices. Next. In terms of reading, singing and telling stories to children, not quite half of US children ages from birth to five are read to everyday, it is at 47.9% exactly. This is unchanged from 2007. Further over 56% of young children are sung to or told stories every day, which is also not statistically different from the 59% in 2007.

Next. This slide shows the percent of children living in "working poor" households. We define that as having parents employed full time with incomes less than 100% of the federal poverty level. What you see on this slide is over one-fifth of children in black or Hispanic households are in this category. Next.

When we looked at smoking, we found that about 24% of US children lived in households with a smoker. This represents a decline from 26% in 2007. In addition, there continues to be a strong socioeconomic gradient with children living in households with the lowest incomes being at the greatest risk of living with a smoker. Next. Moreover, there is over three-fold difference in state prevalence of living with a smoker, from 12.4% in Utah to 41% in West Virginia.

Next please. Overall, although it's not shown on this slide, there were 9.1% of children ages 6-to-17 years old who repeated a grade. What you see here is the variation by household language and you see that Hispanic children, whether Spanish is their primary language or English is their primary language, were more likely to have repeated a grade. Overall, in 2007, 10.6% repeated a grade and further, there were significant decreases for Spanish-speaking children from 2007 to 2011-12.

Next please. Again as Dr. Blumberg mentioned, we wanted to look at, try to look at the whole of the child's life, so we also asked questions about the neighborhood. And here we look at neighborhood amenities and found that the vast majority of US children had access to at least one of the amenities listed here. There were significant increases in some amenities from 2007. For example, in 2011-12 84.6% of children had access to parks or playgrounds in their neighborhood compared to 80.8% in 2007. Likewise, walking paths increased to 76.6% from 73.3% in 2007 and rec centers increased to 69.2% from 65% in 2007. Next. In terms of conditions in the children's neighborhoods, in 2011-12, about 30% of US children lived in neighborhoods with at least one of the three conditions on this slide. These estimates did not change from 2007. Next. Here we see that 86.6% of children were reported by their parents to always or usually feel safe at school. There were, however, distinct socioeconomic gradients with only 74% of children in the lowest SES group reported safe compared to 95% in the highest SES group.

Next. Again, as Dr. Blumberg mentioned, this is the first time that these surveys have examined adverse family experiences as a way to get a fuller sense of the child's life course. What we found is that significant minority children had experienced at least one adverse family experience. The survey also had other questions not shown on this slide, such as whether a parent died or they ever lived with someone who had a problem with alcohol or drugs. What we see on this slide is that over 20 % of children had lived with a parent who was divorced or separated after their birth. Almost 9% of children experienced neighborhood violence, over 7% witnessed domestic abuse and almost 7% had a parent who served time in jail or prison.

Next please. Finally, I'd like to acknowledge the great contributions of Jessica Jones in the Office of Epidemiology and Research and Scott Stumbo, from Oregon Health and Sciences University to this presentation. As I mentioned in the beginning, we've only scratched the surface of what is available on the survey. Next please. And this is my contact information. Thank you very much.

Sarah Lifsey – Altarum Institute – Policy Associate
Great. Thank you so much. As a reminder to our audience, if you have a question for our speakers, you can submit it online at any time using the questions form on the bottom of your screen. Okay, so finally I would like to turn to the last speaker, Dr. Christina Bethell. Dr. Bethell.

Christina Bethell, PhD, MPH, MBA – Oregon Health and Science University – Professor and Director, the Child and Adolescent Health Measurement Initiative
Yes; good afternoon everybody. So I get the fun part to be able to share with you how you can start now to get your hands on some of the micro data, as well as learn more about Stephen's summary of the metadata, or how the data were collected and hopefully we can make that as easy as possible for you. So I'm just going to take a few minutes to give you an overview of the Data Resource Center for Child and Adolescent health, which as Michael mentioned, is supported through the Maternal and Child Health

Bureau and we work closely with both MCHB and of course the National Center for Health Statistics and all of you. So my goal is first and foremost to hopefully inspire you to really make the best use of this data to help advance child well-being from whatever level of health and healthcare you come from. And then to empower you to get your hands on data up to sort of three-way cross tabs, as well as data sets that are already worked up so that can make it easier for you to conduct research or more in depth analyses. And I'd like to challenge all of you on the call today to be thinking about at least one new way that you can by next Tuesday, use this data that Michael and Stephen have been telling you about. Because I think there are some really new exciting variables, as well is tracking from past years, now there's three years of this data set. So, I'm hoping that you'll leave with some action items of your own. And then finally as we get into the questions, I really want to listen carefully and learn from you about how we can really support you more in making the best use of this data.

So I'm going to basically do something very simple. For those of you who know the website, hopefully you'll hear something new. The Data Resource Center does a number of things and one of the key centerpieces of it is our website, where you actually can go on and get the data, micro data and metadata that I'm talking about. Let me just go through it with you a little bit. So first of all, our goal at the Data Resource Center, and we've had the opportunity to be working on this since around 2003-2004, is to create a centralized, user-friendly and interactive access point for national, state, regional findings from the National Survey of Children's Health, as well as the National Survey on Children With Special Healthcare Needs. And to build some shared knowledge, because if we shared ways, common ways of measuring things and defining things, we can actually have a conversation about how we're doing for children, and whether what we're doing in policy and practice is making a difference. And to the extent that we can fast track learning about the data, then we can actually get onto a business of having those Conversations and build capacity for data-driven policy and advocacy in the country.

So of course, we need data for lots of reasons. First of all, it's often very important to educate ourselves about things that we think are true. So studies that are done locally show one thing, but that may be very different than what's going on across the country or in the nation and variations of information. So finding out what's going on in your area and then checking assumptions about what's actually going on in the state or in the nation or in some other area is very empowering in terms of inspiring new ideas and opportunities for improving children's health. Obviously documenting needs and system performance is essential, especially if we are really amping up system change, we want to track and find out where we are now in…at a state level for variety of subgroups of children that you can evaluate that for in these data sets.

And then of course inform and activating partnerships. Partnership is hard sometimes, even long-term partnerships. So data actually can be a very safe haven for having a conversation and finding out whether there's a shared agreement and coming to a shared agreement about what the needs are and aren't and so on and forth. So this data set can really help engage people in a dialogue with each other and then through that, build the partnerships and trust that's needed to really then take on the hard part of changing and creating new ways of doing things often. Obviously educating program leaders and policy makers is essential, and we have a lot of ideas on the website and as well as we can share with you through technical assistance on how to translate this data into ways that leaders and policy makers can hear and make it applicable for them. And then of course, writing grants and conducting research. And we know about many, many, many examples of people who have used the data on the Data Resource Center to write grants and check out their assumptions for sample size and so on and so forth, so that they can actually know more about the data without having to actually do the in-depth analysis that often is not possible to do from a time point of view.

Okay. So, first thing I want to say is, give you a few ideas about what kinds of things you can use the Data Resource Center for. Obviously if you have in-depth analyses you want to get the data set and we

can provide you with the data sets and codebooks and things like that, most of you know that, I'm thinking. But you can actually do quite a lot just with the data query that's available. So you're going to find out that here's US children who are overweight and obese hasn't changed since 2007, but one thing that we want to always encourage is that you use the Data Resource Center to query further in. And so what we allow you to do is look by subgroups age, race, ethnicity, compare across areas and so on and so forth. So even though the overall rate didn't change, a lot of variations did change, and that's really important and is really key to not just pass aside that it didn't change, so nothing happened. Actually, it looks like a lot happened; it just didn't happen on a summary level nationally. So here's another example of some things you can look at. For example, going back to childhood overweight and obesity, we see that this state with be lowest overall rate actually had one of the highest disparities in income. Same thing with the adverse childhood experiences data that Stephen let you know is available. We see a state that had the lowest rate overall of children experiencing two or more adverse child and family experiences, had the greatest variation by household income. So these are just some examples to really encourage you to always look deeper.

Finally, this is one of my favorite myth busting ideas that is possible to look at on the Data Resource Center is often engaging across sectors is essential if we're going to see change. And we know that for many health risks and problems, that the rates or prevalence is often higher for children that are in lower income homes or experience other types of socioeconomic risks. However, it's very important to always look at whether it's true that the bulk of children actually fit that category. So here's an example of people will assume that most overweight or obese children are poor or lack neighborhood amenities for example, when really the truth is that 90% almost of children who are overweight or obese live in neighborhoods who do have recreation centers and parks. So – and the distribution across family income for children overweight or obese is fairly representative of the distribution nationally. So, those are other examples of things that you can find out about today using the Data Resource Center data query.

Okay, so let me just take you through a spin of the website. First of all, as I mentioned, both the National Survey of Children's Health and the National Survey of Children with Special Healthcare Needs data sets are available. And you can interact – receive four different kinds of data. First of all, our data snapshots, where we put a lot of topics together in one place for you at the state level. For example, on healthcare quality or according to Title V needs assessment priorities and there are many, many others. Secondly, our interactive state ranking tables, where you can look at all states at the same time and sort by states, by subgroups of children, so you can see where states rank where you are. And then also you US maps where you can visually see through shading, where your state is compared to the nation and compared to other states. And then finally, where many of you hopefully will be spending a lot of your time is the interactive query for individual survey items, constructed outcomes and composite variables and indicators. And here you can search by state, region and nationwide by a number of population subgroups, and of course the all states piece. And then for trending, you can also trend across here for the survey items and indicators that are possible to compare. And we make that easy for you because we only really allow trending feature for those items that can be compared, so you'll see those alerts in there.

So in addition to the data query, it's very important, we encourage everyone to take time to learn about the surveys, how the survey was collected and we translate some more technical reports into simple documents, and I'm not going to go through a lot of that here today, but I encourage you to click on the learn about survey button on the website to get access to easy to review content maps of what's in the data set, actual interactive capacity for querying the CADI document, which is that big long thick document that's actually the survey, protocol, and so on and so forth. And then also getting expert help.

So let me go right into how you might start getting information. The simplest way is what I call the DRC 360 tour, and that's where you begin by – sorry that little yellow-red bar isn't quite over the US map, but that's where it's supposed to be, where you start with a U.S. map on the right side, browse state

snapshots. So you just click on that and you pick your state, and here we're picking DC, Washington, DC and then you can pick what profile you want to look at, and here we're going to select the overall for the 2011-12 National Survey of Children's Health. And then you receive an overview where we put a number of indicators together in one place and you can compare the District of Columbia to the nation, and you can also see there that you can toggle and change the comparison group interactively. So that's one way to just get an overview, oh, okay, what's in here for health status, healthcare, school and activities, child and family health and so on.

And then if you click on something that you're interested in, and here we're picking insurance coverage, consistency of insurance coverage, you then go right into your state findings into the more in-depth interactive query. And here you see you get both a table and a graph, and these can all be copied and pasted into presentations or Word documents or PowerPoints fairly easily, just right click, copy and paste. And in the table what you'll see is that we give you the estimate, which is weighted to represent the US population if it's national, and your state's population, and then also the confidence interval, so the precision around that estimate and the raw "N" or actual number of children that were surveyed in your state, as well as the population estimate that that number represents, again weighting it back up to the nation or your state. So, you have all of that data which comes in handy as you start to engage people in wanting to learn about the data, they're going to want to know these things. They don't right away, but eventually people are going to say, well how precise is that and how many children does that represent. So, that's what we're making available to you there.

And then what you can do is pick a subgroup. And so we're going to look at by type of insurance, for example. So we're looking at consistency of insurance, by type of insurance coverage, public or private. So you just click on a subgroup that you're interested in and then another table and graph appear. And here you're seeing that for the District of Columbia there is a difference it looks like, we'd have to test that out to see if it was specifically significant between those who are with private insurance and public insurance in the District of Columbia. And it looks like it continues to be slightly higher than the nation with consistent coverage for those who are publicly insured. And that could be, at some point, very useful information to have.

Then you can, if you want at this point, for that particular variable and subgroup, compare the District of Columbia, for example, to all other states. So we allow you in the drop-down menu when you want to search for area, to pick all states as one of the areas if you will. And when you do that, it actually allows a raise all the states against each other and then by clicking on any of the columns; it sorts it by that column. And so you see here the District of Columbia is seventh in line among all the states. And then if you click again in the District of Columbia, it takes you back into the data query. So that's the quickest way we've found to get you in, give you a sense of what's available and help you kind of scroll around and continue to change what it is you want to look at. And at any point, you can change the topic, the area or the subgroup.

So option two is what we call our full search option and that's really, where you go right into the browse by survey and topic. Pick the survey, the survey year and the area you want to look at and then select the starting point topic that you're interested in, where you drive the car this time, instead of us picking what the topics are and then going from there, you start right away by picking what topics you're interested in. So here you can just see that I'm picking health status, and then you'll see a list of variables that are related to health status and that little "eye" button that's over there, if you click on that it will tell you how the variable was constructed, the numerator, the denominator, any concerns that you may want to have about that variable from a validity point of view and if there are some references that are key, where the survey items came from or something, we put those in the pop-up boxes. So you can find out about it right there interactively as well.

So we're looking at missed school days this time and it arrays it in zero days up to two or more weeks. This is again still looking at – I think we're still in the District of Columbia – no, this is nationwide. And again, from this point, you can look at your state or region and a subgroup and so on. So, if you get in, you'll see how that goes. So, I really want to encourage you to also take advantage of the materials that we put on the website to assist you. First of all, there are frequently asked questions. They are questions we get all the time about how to interpret, for example, the data that – where there's maybe not as much sample, how do I handle that or how did you construct medical home or something like that. So we have frequently asked questions. We also have an online tour, very simple, little visuals that you can send your colleagues to or that you might want to take, that actually gives you a tour, just like I did, as well as going to the next level of thinking about how to interpret the data and thinking about using it. So we have a couple of different online tours.

There's fast-fact documents where you can just download one-pagers on the content that's in the survey, a visual map, as well as how it was sampled and the data was collected. And then, of course, the interactive guide to topics and questions asked that makes it very simple for say a group of people to find out what's in the survey that you might want to look at together. And if you still have a question, you can e-mail us and we get back to you sometimes within seconds, but always within a day or so, and depending on the nature of your question, we can often help you right away or make sure that we respond to your needs. I don't think we've ever really turned anyone away, so please contact us.

So some of the other features that I want to make sure you know about, is the – you can order, through filling out a form and download cleaned, labeled survey data sets with pre-constructed indicators, so that you don't have to do that, and additional variables as well. And we also have SAS and SPSS codebooks and can provide the data sets in a number of file formats for you. We also have ways to learn about how to use the data for different contexts. For example, educational settings and working with student and student training, we have materials there. Looking at educating policymakers and for legislative briefings, there's examples of people who have done that with the data. Issue briefs linked to peer review papers and so on and so forth. And then of course we encourage you to sign up for eUpdates. We have very few of them, but when we do have them, we try and make them as informative as possible and I encourage you to sign up for them, and you will not get spam.

So basically, I'm going to end with just pointing a couple of things out. One is, this is the era of health reform and I just want to make sure you all know that this data set includes quite a few variables that are aligned with the CHIPRA pediatric quality measures format for how we're supposed to measure quality under the CHIPRA legislation. And this is a table that aligns with what are the variables in each of those areas, and many of these have actually been endorsed through the National Quality Forum for use. So for those of you who are interested in looking across states and for subgroups of children in states, by for example public insurance and race, ethnicity or children with special health care need status, that's something you can do today for a number of CHIPRA and Health Reform relevant variables.

We have a specific profile on how to use the DRC to support improvement partnerships, which many states have at various levels. Especially now that we're trying to really focus on whole child health and population health, that this is a data set and the National Survey of Children with Special Healthcare Needs as well, that the Maternal and Child Health Bureau has led to make sure that you understand your population, assess system performance, examine improvement opportunities against other areas in your state. Groups of populations in your state that are doing better or worse than other states, and learn from that. Select priorities, set targets, maybe compare to how a top performing state or subgroup is doing, that can help you set targets. Identify promising improvement models; especially if you see a pocket of excellence, you want to know about that. And then of course, monitor progress over time. And if you want, could use some of the same metrics and same methodologies to collect this data locally or in health

plans or local groups, so you can compare and benchmark what you're measuring against the national data.

So I'm going to leave it there and just let you know we're here and we look forward to hearing from you. And I hope you can make the data come alive as you speak about it. This last little fun slide is just to show you that, for example, in California there are enough children with asthma to fill up 20 Staples Centers. We're talking a lot of children who really, really need our collective effort to improve their health and healthcare. So I hope you will take this opportunity to use this amazing data and be as bold as possible in doing so. Thank you for your time.

Sarah Lifsey – Altarum Institute – Policy Associate
Great. Well thank you so much and thanks again to everyone who has presented today. We already have some questions coming in and we've got a few minutes for the Q&A here at the end. We can take questions both online and on the telephone. We've already talked about how to enter them online, but if you want to ask the question on the phone, just press star-1 to indicate that you have a question and the operator will let us know that there's a question, and indicate to you when to ask. So I'm just going to start off with some of the questions that we have received online, and the first question I have is from Chris, and it's for Dr. Kogan. On first review, what findings stand out to you as either encouraging or troubling?

Michael Kogan, PhD – Maternal and Child Health Bureau – Director, Office of Epidemiology and Research
Good question. As I mentioned in the talk, I would say the findings on breast-feeding are very good news. I think it's troubling that we see increases in certain – the prevalence of certain conditions that are emotional, behavioral and developmental like ADD, ADHD, speech problems and anxiety problems. I think it's very encouraging that there's been a decrease in those children who are reported to be uninsured. And, I mean, those would be the things that would stand out for me right now. I think it was interesting that when we first compared a lot of the estimates from 2007 to 2011-12, I was struck by how many stayed the same.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay, great. Thank you. The next question I have is for Dr. Blumberg and also Dr. Bethell and it's from Divia, what percentage of the sampling were American Indians and for states like North Dakota that have a large American Indian population, is there a way that you can look at this data for this population on the DRC website ?

Stephen Blumberg – National Center for Health Statistics, Centers for Disease Control and Prevention – Associate Director for Science, Division of Health Interview Statistics
This is Stephen. While I don't have the numbers in front of me, we certainly would expect as a result of the sampling, to essentially get the same percentage of Native American children as there are in the state. Now in states where there are more than 5% American Indian or Alaskan native children, we do report their race on the public data files and so for those states, yes you can do analyses specifically for the American Indian and Alaska native population.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay, great. Dr. Bethell, is there a way to look at the information on the website? You may be still muted, but we can come back to that question.

Christina Bethell, PhD, MPH, MBA – Oregon Health and Science University – Professor and Director, the Child and Adolescent Health Measurement Initiative
Yeah, I was still muted, I was actually speaking. Sorry about that, I was starting to be sensitive. Yeah, no, the best thing to do is just contact us directly and then we can make sure that depending on the variable and subgroup you're interested in, that that data can be validly reported, because even though it's available, it's still not something that is robust for every single subgroup within that race group. So, we would like to try to – so we'd just do it the same way as we have in the past.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay, great.

Christina Bethell, PhD, MPH, MBA – Oregon Health and Science University – Professor and Director, the Child and Adolescent Health Measurement Initiative
And of course, if you want the data set, you can get the data site directly.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay. I think that we can take – we have time for just a couple of more questions if our speakers are willing to just answer just a few more. But for the folks who need to go at 4, I want to point out that if you have any additional questions, you can e-mail them to us at DataSpeak@Altarum.org and answers to those questions that we are not able to address during our Q&A period today, will be posted in writing along with the program archive. And we also want to you know that we'll be broadcasting more DataSpeak programs in the coming months and announcements about those future DataSpeak programs will be sent out via e-mail to everyone who registered for today's program.
And we just have a few more questions. I have one from online from James, are there any questions to measure the engagement of parents in school or the engagement of parents in the community?

Stephen Blumberg – National Center for Health Statistics, Centers for Disease Control and Prevention – Associate Director for Science, Division of Health Interview Statistics
This is Stephen. Beyond the question that asks the extent to which parents know their children's friends, we don't have questions that are specific about engagement in the school system or the local school or engagement in the community. No, we don't.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay, thanks.

Christina Bethell, PhD, MPH, MBA – Oregon Health and Science University – Professor and Director, the Child and Adolescent Health Measurement Initiative
There are variables on the engagement of the child, but not – which I don't know if that's a proxy or not, but it's not the parent, like Stephen said.

Sarah Lifsey – Altarum Institute – Policy Associate
Great. I have a question from online from Karen. So it appears that health insurance for children increased in 2011-2012 compared to 2007, but access to a medical home appeared to decrease. Was this decrease in medical home access significant and if so, how do you explain that along with the increase in health insurance for children?

Michael Kogan, PhD – Maternal and Child Health Bureau – Director, Office of Epidemiology and Research
This is Michael. The two, while related don't necessarily go hand-in-hand. Remember that yes, first this decrease was significant from 2007 to 2011-12 for those who had a medical home. But second remember the medical home is comprised of five different variables and while someone could have access, they could have – there could have been more problems obtaining care coordination or referrals if they were needed, and that might drive down the percent of those who were considered of having a medical home.

Sarah Lifsey – Altarum Institute – Policy Associate
Okay. Great. Thanks. I think we have time for one more question from online and I have a question from Kathy. With the increase of obesity in our nation, we are hearing about the increase in diabetes type 2 in children, did the data address that issue?

Stephen Blumberg – National Center for Health Statistics, Centers for Disease Control and Prevention – Associate Director for Science, Division of Health Interview Statistics
We do have question about diabetes and whether the child has ever been diagnosed with diabetes and whether the child currently has diabetes. I don't know if that will be sufficient for our listener.

Sarah Lifsey – Policy Associate, Altaum Institute
Okay, is there a way to explore the data on the Data Resource Center website?

Christina Bethell, PhD, MPH, MBA – Oregon Health and Science University – Professor and Director, the Child and Adolescent Health Measurement Initiative
 Yes. Yes, just follow your nose and you should be able to find it, if not ...

Sarah Lifsey – Altarum Institute – Policy Associate
Great. Thank you. Well, and I did have one question from online that I can answer, which is the instructions to how to download today's presentation materials. You can download those on the left-hand side of the screen by clicking on the slide presentation, clicking the download files and just follow the instructions there. And the slide presentation will also be posted along with the archive, when the material is archived.
So finally, before you logout, we would greatly appreciate you taking a moment to provide us with feedback on today's program. It's really important to us that we have your input on this session, as well as your recommendations for future programs. So to fill out this very short survey, simply click on the evaluation link on the screen now and the survey will open up in a new window. I think that brings us to the conclusion of today's program. Thanks to all of our speakers, thank you all for joining us and have a great afternoon.
12 More questions and answers can be found in the document located at: http://mchb.hrsa.gov/ researchdata/mchirc/dataspeak/archivedevents/april2013/files/201300416QandA.pdf