1998 CSTE ANNUAL MEETING

CSTE POSITION STATEMENT # CD 6

COMMITTEE: Chronic Disease

TITLE: Inclusion of Cardiovascular Disease Indicators in the National Public Health Surveillance System (NPHSS)

POSITION TO BE ADOPTED: Population-based, cardiovascular disease (CVD) mortality and screening indicators should be included in the National Public Health Surveillance System (NPHSS).

BACKGROUND/JUSTIFICATION: Cardiovascular disease is the leading cause of death in the United States, accounting for approximately 40 percent of all deaths. Substantial differences in CVD death rates and preventive measures exist by race, age, sex, place of residence, and other demographic groups.

CVD can be prevented or controlled through preventive measures that include blood pressure and cholesterol screening. Screening for high blood pressure among all adult populations is a commonly accepted and practiced preventive measure. While the appropriate age and risk factor profile of populations to screen for cholesterol abnormalities are not universally agreed upon, clinical advisory groups, including the United States Preventive Services Task Force, have recognized its benefit and recommended its practice among specific populations.

Federal funds were recently appropriated to develop state-based programs to improve cardiovascular health. Public health programs to reduce tobacco use, a major risk factor for cardiovascular disease, are operational in each state. In addition, many states have public health efforts to reduce physical inactivity, improper nutrition, obesity/overweight, and other CVD risk factors, and to detect and control hypertension, cholesterol abnormalities, and diabetes.

GOALS FOR SURVEILLANCE:

a. Local:
   - Secure intervention resources appropriate to the burden of cardiovascular mortality in that locality
   - Measure the impact and preventable fraction of disease
   - Monitor trends

b. State:
   - Measure the impact and preventable fraction of disease
   - Monitor trends
   - Identify geographic areas or population groups with excessive preventable/modifiable CVD outcomes
   - Obtain and allocate limited public health resources for CVD prevention and control

c. National:
   - Measure the impact and preventable fraction of disease
   - Monitor trends
   - Identify geographic areas or population groups with excessive preventable/modifiable CVD outcomes
   - Obtain and allocate limited public health resources for CVD prevention and control
   - Develop hypotheses about risk factors for disease outcomes and effective interventions to prevent or control CVD outcomes

PROPOSED METHOD OF SURVEILLANCE:

a. Local:
   - Vital (death) registration system
   - Risk factor surveys as available

b. State:
   - Vital (death) registration system
   - Behavioral Risk Factor Surveillance System (BRFSS)

c. National:
   - Vital (death) registration system
   - BRFSS
   - National Health Interview Survey (NHIS) - Health Promotion/Disease Prevention Supplement
   - National Health and Nutrition Examination Survey (NHANES)

PROPOSED SURVEILLANCE DEFINITION:

ICD - 9 rubrics for each category of CVD mortality recommended to be included in the NPHSS are listed in Table 1, as well as the estimated number of deaths per year (underlying cause of death). Numbers and population-based rates of death should both be monitored and reported. Denominators for rates should be the census population estimate for the same year as that of the numerator and for the geographic jurisdiction in the appropriate demographic group. Deaths and population estimates should be by resident status. Rates should be age-adjusted by 10-year age groups by the direct method to the population of the United States. Rates based upon a small number of deaths may be unstable and should be interpreted with caution.

Measures that indicate recency of screening for clinical abnormalities (ages 18 years and older) are also recommended to be added to NPHSS (Table 2). Measures of the recency of screening are currently collected on a biannual basis by all states and territories participating in the BRFSS. National screening indicators are also collected through the NHIS and NHANES. Prevalences should be displayed by age, race, sex or other demographic or geographic characteristic, especially for the populations for which the clinical efficacy of these measures has been established and is commonly accepted. Prevalences based upon a small number of observations may be unstable and should be interpreted with caution.

DATA TO BE COLLECTED:

a. Local:
   - Death certificate information
b. State:
   - Death certificate information
   - Random telephone survey of adult population (e.g., BRFSS)
c. National:
   - Death certificate information
   - Population data (for denominators for death rates) (collected by Census Bureau)
   - Collection of data from states participating in BRFSS
   - Collection of data through NHIS, NHANES

INFORMATION SYSTEM TO BE UTILIZED TO COLLECT AND TRANSMIT INFORMATION:

Death Registration System (local, state and national)
Behavioral Risk Factor Surveillance System (state and national)
National Health Interview Survey (national)
National Health and Nutrition Examination Survey (national)

TEMPORARY/PERMANENT:

Permanent

PARTNER ORGANIZATIONS & ROLE IN SURVEILLANCE ACTIVITY:

National Association for Public Health Statistics and Information Systems (NAPHSIS)
National Center for Health Statistics (NCHS)

- Establish and encourage utilization of rules, procedures, and quality standards for collecting, analyzing, and reporting information from death certificates.

National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH)
Division of Adult and Community Health (DACH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC)

- Analyze and monitor CVD surveillance data to develop and test hypotheses related to factors for prevention and control of CVD; assure surveillance data are brought to bear on policy decisions related to research on risk factors and interventions

DACH, NCCDPHP:

- Establish and encourage utilization of rules, procedures, and quality standards for collection, analysis, and reporting of BRFSS data
- Analyze and monitor BRFSS surveillance data to develop and test hypotheses as to risk factors for prevention and control of CVD

Association of State and Territorial Health Officials (ASTHO), especially:

Association of State and Territorial Chronic Disease Program Directors(ASTCDPD)
Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE)
Association of State and Territorial Public Health Nutrition Directors (ASTPHND)

- Adopt and support surveillance efforts; develop public health programs and health policy utilizing surveillance data

National Association of City and County Health Officials (NACCHO):

- Adopt and support surveillance efforts; develop public health programs and health policy utilizing surveillance data

FEDERAL AGENCY/DATA SYSTEMS INVOLVED:

CDC/NCHS
-Vital (Death) Registration
CDC/NCCDPHP
- BRFSS
CDC/NCHS
- National Health Interview Survey; National Health and Nutrition Examination Survey

COORDINATION WITH OTHER ORGANIZATIONS:

Agency for Response: Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

Agencies for Information: National Center for Health Statistics, CDC
National Health, Lung and Blood Institute, National Institute of Health

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Table 1. Categories and ICD-9 Rubrics for Cardiovascular Disease Mortality (underlying cause of death), Recommended to be Added to the National Public Health Surveillance System, 1998.

Category	ICD-9 Rubric	Approximate Annual Number of Deaths (1995)
Total CVD	390-459	956,000
Heart Disease	390-398, 402, 404-429	738,000
Coronary Heart Disease	410-414 410-414, 429.2	481,000 552,000
Congestive Heart Failure	428.0	43,000
Cerebrovascular Disease	430-438	158,000

Table 2. Cardiovascular Screening Measures Recommended to be Added to the National Public Health Surveillance System, 1998.

	Current Definition	Estimated Prevalence (1995)
Recency of Cholesterol Screening	Cholesterol checked in past five years (18+ years of age)	65%
Recency of Blood Pressure Screening	Blood pressure checked in past year (18+ years of age)	90%