

Office of Analysis and Epidemiology Program Review: Two years later

Presentation to the NCHS Board of Scientific Counselors

Irma Arispe, Director, OAE

(With thanks to Anthony Rizkalla, Makram Talih, and the staff of OAE!)

May 19, 2016

National Center for Health Statistics

Office of Analysis and Epidemiology



OAE's Program Review

OAE presented its self-assessment to the BSC in September 2013. The program review was held the following spring, with recommendations in May 2014.

Program Review BSC Recommendations:

- Develop a Strategic Vision
- Conduct Systematic Evaluation and Capture User Data and Feedback
- Establish Priorities and Align Resources

Other BSC Recommendations

- Establish or Formalize New Partnerships and Cooperative Ventures
- Support and Enhance Staff Development and Deployment
- Define and Improve Data Dissemination
- Determine Data Linkage Needs and Opportunities

Coinciding with BSC recommendations

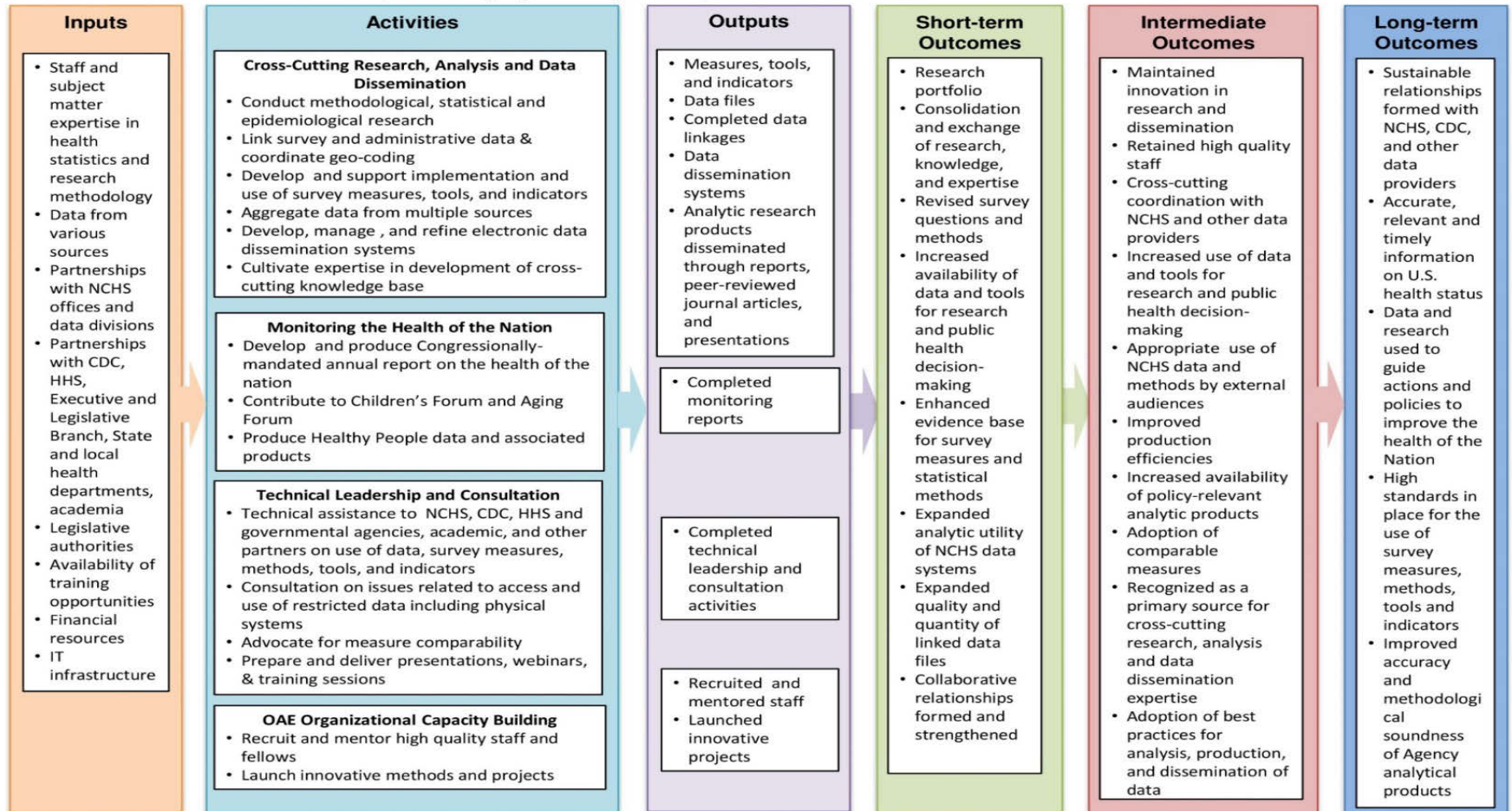
- Discussions with senior leadership on priorities
 - Timeliness, relevance, orientation to data visualization
- Review of major programs for CDC's Quarterly Program Review
 - Identify which programs to highlight, how to examine on routine basis
- Systematic capture of feedback, product uses
 - Engagement of CDC Evaluation Fellow
 - Employee Viewpoint Survey
 - Collection and analysis of data for key programs

Establishing mission, and vision

What do we do and why?

Office of Analysis and Epidemiology Logic Model

The Office of Analysis and Epidemiology (OAE) serves NCHS, CDC, HHS, and the broader national and international health and health care communities by using data from NCHS and other sources to inform policies and programs designed to improve the Nation's health.



OAE Mission and Vision


Mission: The NCHS Office of Analysis and Epidemiology serves NCHS, CDC, HHS, and the broader national and international health and health care communities by using data from NCHS and other data sources to inform policies and programs designed to improve the Nation's health.

Vision: We strive for

- scientific excellence in our work
- innovation in our research and dissemination products
- leadership in timely and relevant work on important public health and health policy initiatives.

NCHS data cited as an objective, unbiased, and accurate source of information

How do we assess our progress in maintaining scientific excellence?



Congressional Budget Office
MARCH 2016

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026

Provided as a convenience, this "screen-friendly" version is identical in content to the principal ("printer-friendly") version of the report. Any tables, figures, and boxes appear at the end of this document; click the hyperlinked references in the text to view them.

Summary

The federal government subsidizes health insurance for most Americans through a variety of federal programs and tax preferences. In 2016, those subsidies for people under age 65 will total more than \$600 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. (The government also bears significant costs for health insurance for people 65 or older, mostly through Medicare and Medicaid.)


Notes: As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (PL 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the tables and figures may not add up to totals because of rounding.

Unless otherwise indicated, all years referred to in describing estimates of mandatory spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average enrollment in any given month of a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Supplemental data for this report are available on CBO's website (www.cbo.gov/publication/51385).



Congressional Research Service
Informing the legislative debate since 1914


Specialty Drugs: Background and Policy Concerns

Suzanne M. Kirchoff
Analyst in Health Care Financing

August 3, 2015

Congressional Research Service
7-5700
www.crs.gov
R44132

CRS REPORT
Prepared for Members and Committees of Congress



GAO
U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Testimony
Before the Subcommittee on Primary Health and Aging, Committee on Health, Education, Labor, and Pensions, U.S. Senate

HOSPITAL EMERGENCY DEPARTMENTS
Health Center Strategies That May Help Reduce Their Use

Statement of Debra A. Draper
Director, Health Care

GAO
U.S. GOVERNMENT ACCOUNTABILITY OFFICE

GAO-11-627T

Vision:

→ Scientific excellence

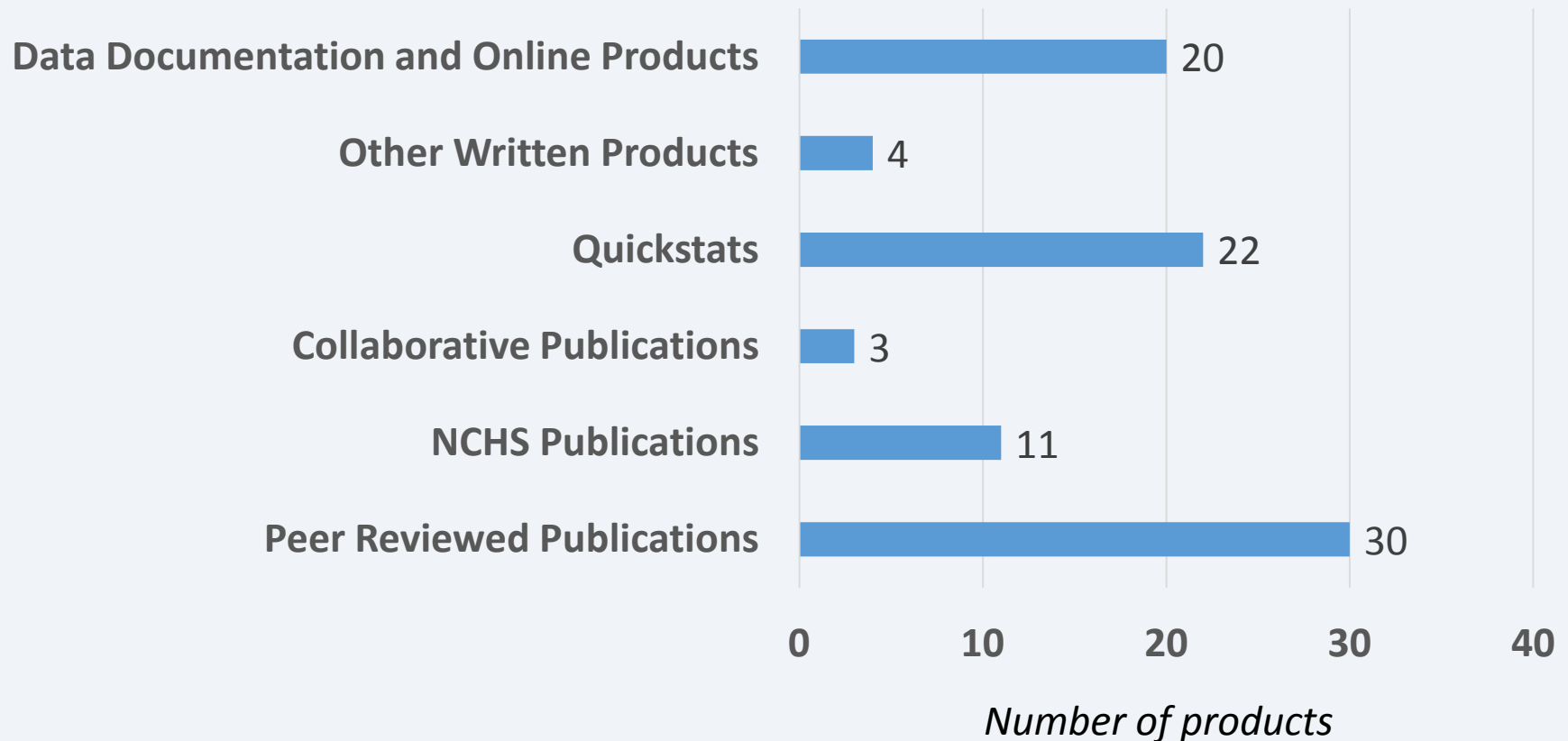
- Innovation in research, dissemination
- Leadership in timely, relevant research

Structures and processes for promoting scientific excellence

- An Associate Director for Science: Makram Talih!
 - Liaison with NCHS ADS, improved quality and efficiency of products
 - A new OAE concept clearance process
 - An improved understanding of our research: what we are doing and why
- OAE participation in NCHS' science policy and methods research
 - Test of trends
 - Data suppression
 - Cross cutting, methods research

How do we assess scientific excellence?

Through a diverse portfolio OAE analytic products, 2015 (N=90)



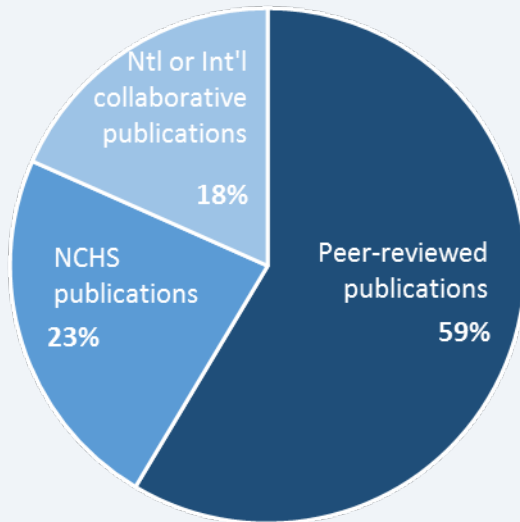
What are we doing and why?
How do we use this mix to best serve our mission and vision?

Through diverse research collaborations

Analysis of OAE Publications 2012 through 2015

Types of OAE-authored written analytic products, 2012–2015

n = 169

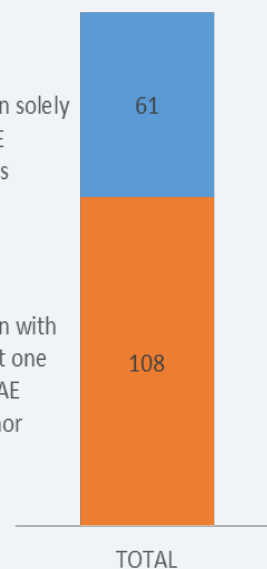


Number of OAE-authored written analytic products, 2012–2015

n = 169

Written solely by OAE authors

Written with at least one non-OAE coauthor

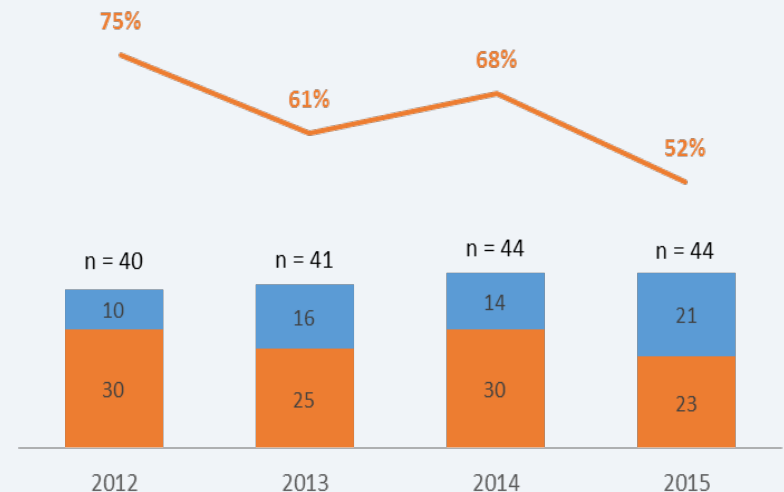


Number of OAE-authored written analytic products, 2012–2015

Written solely by OAE authors

Written with at least one non-OAE coauthor

Percentage written with at least one non-OAE coauthor



What's the "right" number?
The right mix?

Innovation in Research ...

National Health Statistics Reports

Number 89 ■ January 22, 2016

Proposed Framework for Presenting Injury Data Using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis Codes

by Holly Hedegaard, M.D., M.S.P.H., National Center for Health Statistics; Renee L. Johnson, R.R.T., M.S.P.H., National Center for Injury Prevention and Control; Margaret Warner, Ph.D. and Li-Hai Chen, M.S., Ph.D., National Center for Health Statistics; and J. Lee Annest, M.S., Ph.D., National Center for Health Statistics

Abstract

Frameworks based on the International Classification of Diseases (ICD) provide injury researchers and epidemiologists with standard approaches for presenting and analyzing injury-related mortality and morbidity data. Injury diagnosis frameworks, such as the Brief Matrix for the ICD Ninth Revision, Clinical Modification (ICD-9-CM) and the Injury Mortality Diagnosis Matrix for the ICD Tenth Revision (ICD-10), categorize ICD codes into major body regions (e.g., head, chest, abdomen, or extremity) by nature-of-injury (e.g., fracture, laceration, organ injury, or vascular injury) categories. In the United States, morbidity coding transitioned from ICD-9-CM to ICD-10-CM on October 1, 2015. In preparation for the use of ICD-10-CM-coded morbidity data for injury surveillance and data analysis, the National Center for Health Statistics and the National Center for Injury Prevention and Control propose an ICD-10-CM Injury Diagnosis Matrix to provide a standard approach for categorizing injuries by body region and nature of injury. This report provides a brief description of the differences between ICD-9-CM and ICD-10-CM injury diagnosis codes, introduces the proposed framework and the methods used to create it, and provides a list of additional considerations for review and comment by researchers and subject-matter experts in injury data and surveillance.

Keywords: injury diagnosis • classification • traumatic brain injury

Introduction

Since the early 1990s, the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics (NCHS) and National Center for Injury Prevention and Control (NCIPC) have collaborated with colleagues from the International Collaborative Effort (ICE) on Injury Statistics and the American Public

Health Association Injury Control and Emergency Health Services section to improve the analysis and usefulness of fatal and nonfatal injury data in the United States and internationally. One aspect of this collaboration is the development of frameworks or matrices based on standard groupings of International Classification of Diseases (ICD) codes for presenting fatal and nonfatal injury data by external causes of



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics



SAFER • HEALTHIER • PEOPLE

National Health Statistics

September 2015
Number 58

Linkage of NCHS Population Health Surveys to Administrative Records From Social Security Administration and Centers for Medicare Medicaid Services

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

Healthy People Statistical Notes

Healthy People 2020

Number 27

February 2016

Measuring Progress Toward Target Attainment and the Elimination of Health Disparities in Healthy People 2020

by Makram Talib, Ph.D.; and David T. Huang, Ph.D., M.P.H., C.P.H., Office of Analysis and Epidemiology

Abstract

Introduction—Healthy People is an initiative of the U.S. Department of Health and Human Services that provides science-based, 10-year national objectives for improving the health of all Americans. As in the previous three decades, Healthy People 2020 (HP2020) has established overarching goals and objectives, and is monitoring progress toward the attainment of its targets as well as the elimination of health disparities among population groups. This Statistical Note discusses the HP2020 measurement practices, contrasting them with those that were in place in Healthy People 2010 (HP2010) and highlighting their strengths and limitations.

Objective—This Statistical Note documents the HP2020 methodology for measuring progress toward target attainment and the elimination of health disparities, with a particular focus on methodological considerations for the interpretation of findings.

Progress toward target attainment—For HP2020, the “percent of targeted change achieved” still measures movement of objectives that are moving from their baselines toward their targets. However, for objectives moving away from their baselines and targets, the

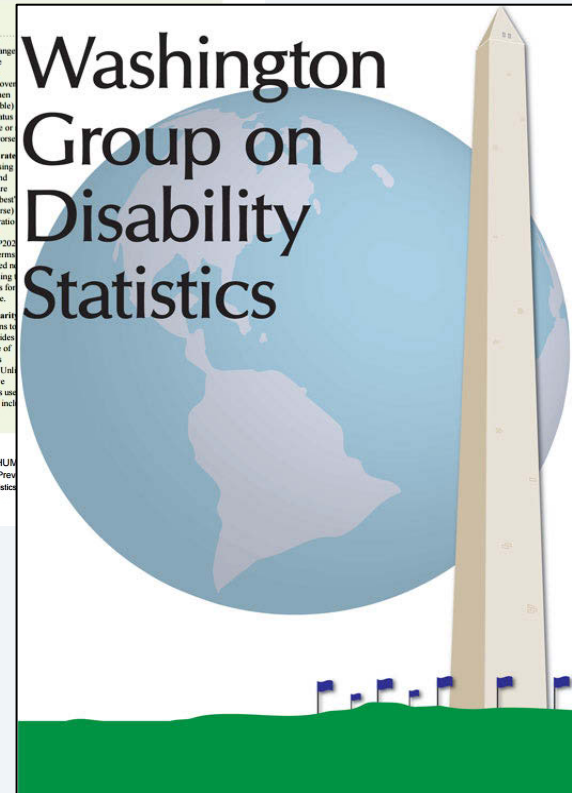
“absolute value of the percent change from baseline” is used to measure movement. In addition, unlike in HP2010, both the extent of the movement and its statistical significance (when measures of variability are available) are used to determine progress status (HP2020 (e.g., “improving,” “little or detectable change,” or “getting worse”).

Comparisons to the best group rate—As in HP2010, all groups composing a population domain (e.g., race and ethnicity, education, or income) are compared to the group with the “best” (i.e., most favorable or least adverse) rate. However, HP2020 uses the ratio instead of the percent difference between the rates. In addition, HP2020 objectives that are expressed in terms of favorable outcomes to be increased no longer need to be re-expressed using complementary adverse outcomes for comparisons to the best group rate.

Measures of overall health disparity—In addition to detailed comparisons to the best group rate, HP2020 provides measures that quantify the degree of disparity overall across all groups composing a population domain. Unlike in HP2010, where a single relative measure, the summary index, was used, HP2020 uses three measures that incl



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



Vision:

- Scientific excellence
- Innovation in research, dissemination
- Leadership in timely, relevant research

...and dissemination



Health, United States Spotlight

Selected Health Indicators Winter 2014

ABOUT HEALTH, UNITED STATES

Health, United States is the annual report on health, produced by the National Center for Health Statistics and submitted by the Secretary of Health and Human Services to the President and Congress. The report uses data from government sources as well as private and global sources to present an overview of national health trends. This infographic features one health indicator from each of the report's four subject areas.

For more information, visit the Health, United States website at: <http://www.cdc.gov/nchs/hsus.htm>.

Four Subject Areas of Health, United States

- Health status & determinants
- Health care resources
- Utilization of health resources
- Health care expenditures & payers

CIGARETTE SMOKING

ABOUT THE DATA

Sources: CDC/NCHS/National Health Interview Survey (NHIS)

Respondents are:

- Civilians
- Not part of Armed Forces active duty
- Noninstitutionalized
- Not living in a long-term care facility
- Not incarcerated

Note: The definition of "current cigarette smoking" does not include use of e-cigarettes.

Current cigarette smoking among adults aged 18 and over, by sex: 2004-2014

A "CURRENT SMOKER" For adults (18 and over):

- His smokes 100+ cigarettes in his or her lifetime
- Now smokes every day or some days

Cigarette smoking among adults **DECREASED 20%** in 10 years (2004-2014).

In 2014, adult men were **1.3 TIMES AS LIKELY** as adult women to be current cigarette smokers.

NURSING HOMES

ABOUT THE DATA

In 2014, there were **15,643** NURSING HOMES

In 2014, approximately **81%** of all beds were occupied in the U.S.

Five highest and five lowest occupancy rates in the United States: 2014

Office of Disease Prevention and Health Promotion health.gov healthfinder.gov HealthyPeople.gov

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Topics & Objectives | Leading Health Indicators | Data Search | Healthy People in Action | Tools & Resources | Webinars & Events | About

Search for Data on Health Disparities

Did you know you can use DATA2020 to view health disparities data by sex, race/ethnicity, educational attainment, and family income?

Get started.

CDC Centers for Disease Control and Prevention CDC 24/7: Saving Lives. Protecting People™

Search NCHS SEARCH

CDC A-Z INDEX

National Center for Health Statistics

NCHS Data Linkage

NCHS Data Linkage Activities

- NCHS Mortality Data
- CMS Medicare Enrollment and Claims Data
- CMS Medicaid Enrollment and Claims Data
- USRDS End-Stage Renal Disease Data
- SSA Benefit History Data
- HUD Rental Assistance Program Data
- FAQs

Summary of Available Linkages

The following table presents the NCHS surveys and the administrative data sources each is linked to:

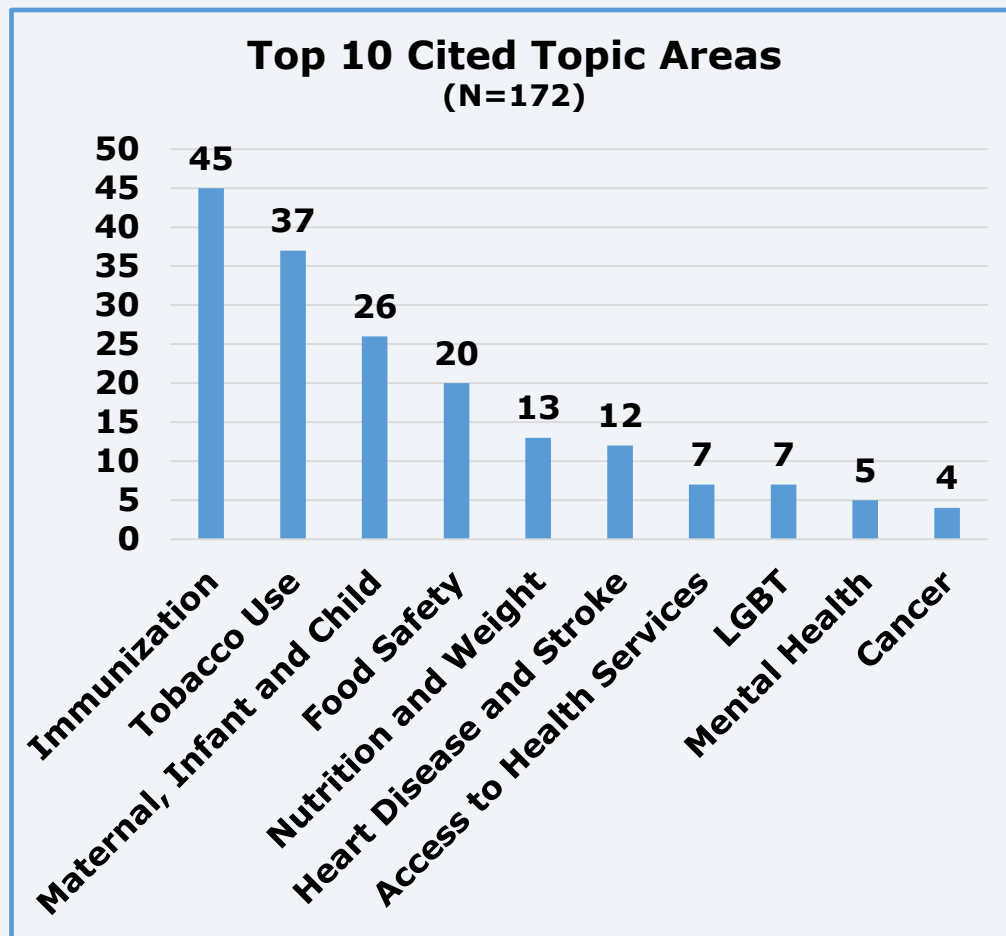
- Data Linkage Resources by NCHS Health Statistics (PDF - 16 KB)

Healthy People 2020 Related News Coverage

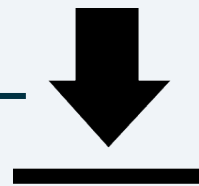
By Data Source and Topic Area, October 2015 to March 2016

Bloomberg Government Analysis
October 2015 to March 2016

- 247 News stories referencing Healthy People 2020
 - 131 cite data (53%)
 - 112 cite NCHS survey data by name (45%)
 - 50 cite NHIS
 - 22 cite NHANES
 - 16 cite DVS Data



Health, United States Web Page Activity



97,005
DOWNLOADS
JAN. 1–DEC. 31, 2015



Most Popular Report Downloads


- *Health, US 2010* with Special Feature on Death and Dying
- *Health, US 2014* with Special Feature on Adults Aged 55-64
- *Health, US 2013* with Special Feature on Prescription Drugs
- *Health, US 2012* with Special Feature on Emergency Care
- *Health, US 2011* with Special Feature on Socioeconomic Status and Health

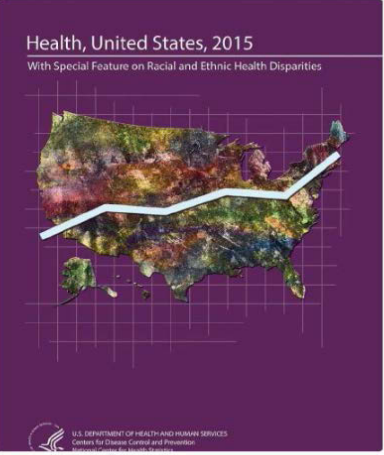


Most Popular Data Table Downloads

- Personal health care expenditures (HUS 2014)
- Healthy weight, overweight, and obesity among adults aged 20 and over (HUS 2014)
- Use of selected substances in the past month among persons aged 12 and over (HUS 2014)
- Gross domestic product and national health expenditures (HUS 2013)

Promotional Tweet

 Pinned Tweet
 NCHS @NCHStats · Apr 27
 Download new [#HealthUS15](#) report w/ special feature on Racial & Ethnic Health [#Disparities](#) go.usa.gov/csZm9



Health, United States, 2015
 With Special Feature on Racial and Ethnic Health Disparities

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Centers for Disease Control and Prevention

28 17

Twitter Countdown

 NCHS @NCHStats · Apr 24
 New Special Feature on Racial & Ethnic Health [#Disparities](#) coming out Wed go.usa.gov/csZm9 [#HealthUS15](#)




Find it here:
www.cdc.gov/nchs/hus/

Look out for Tweets with [#HealthUS15](#)

8 3

- **48 Tweets** posted during week of *Health, United States* release
- Increased engagement with polls, figures, and animated images

Twitter Poll

 NCHS @NCHStats · Apr 27
 In 2014, life expectancy at birth in the United States for the total population was:

25% A. 75.3 years


63% B. 78.8 years

12% C. 81.1 years

8 votes • Final results

1

Tweets on Key Findings

 NCHS @NCHStats · Apr 27
 Men are more likely than women to be current [#cigarette](#) smokers in U.S. go.usa.gov/ctdJH [#smoking](#) [#HealthUS15](#)

13 8


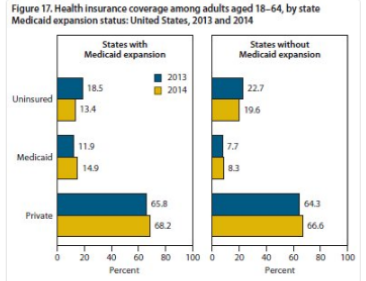
 NCHS @NCHStats · Apr 27
 Bigger decline in % uninsured adults 18-64 for [#Medicaid](#) expansion vs nonexpansion states go.usa.gov/czuVm

Figure 17. Health insurance coverage among adults aged 18-64, by state Medicaid expansion status: United States, 2013 and 2014



Insurance Type	States with Medicaid expansion	States without Medicaid expansion
Uninsured	18.5 (2013), 13.4 (2014)	22.7 (2013), 19.6 (2014)
Medicaid	11.9 (2013), 14.9 (2014)	7.7 (2013), 8.3 (2014)
Private	65.8 (2013), 68.2 (2014)	64.3 (2013), 66.6 (2014)

Exact and PowerPoint <http://www.cdc.gov/nchs/hus/content/2015/figure17>

Leadership on Timely and Relevant Issues

PBS NEWSHOUR SUBSCRIBE

THE RUNDOWN A BLOG OF NEWS AND INSIGHT

HEALTH SUPREME COURT VOTE 2016

HEALTH

New report reveals persistent health disparities by race in the U.S.

BY LAURA SANTHANAM AND MEGAN CRIGGER April 27, 2016 at 12:01 AM EDT



A new government report that serves as the nation's health report card shows that all health indicators

Vision:

- Scientific excellence
- Innovation in research, dissemination
- ➔ Leadership in timely, relevant research

On Point with Tom Ashbrook Twitter Facebook

TODAY IS WEDNESDAY, MAY 11, 2016 SEARCH Google Custom Search

On Point Embed

Why Life Expectancy Varies Greatly In The U.S.


0:00 / 46:41 823 plays

Download this story

May 10, 2016 at 10:00 AM Facebook Twitter E-mail

Why Life Expectancy Varies Greatly In The U.S.

How long are you likely to live in America? And why? We'll look at race, gender, money- and American lifespans now.



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ONPOINT TODAY

Breaking Down The 'Brexit'

May 11, 2016 | 48 Comments

Should Britain stay in the European Union or take an exit? The Brexit? We'll hear the debate from across the pond. Plus, we'll talk about London's new mayor Sadiq Khan.

Michael Brown's Mother On Her Son's Life, Death

May 11, 2016 | 16 Comments

Michael Brown's death in Ferguson by a white police officer set off a nation-wide debate on racial justice. His mother is now speaking out. She joins us. Plus, a closer look at the scrutiny surrounding the black female West Point cadets who posed for a photo with hands raised in fists.

RECENT SHOWS

The Growing Allure Of The Gap Year

Guests

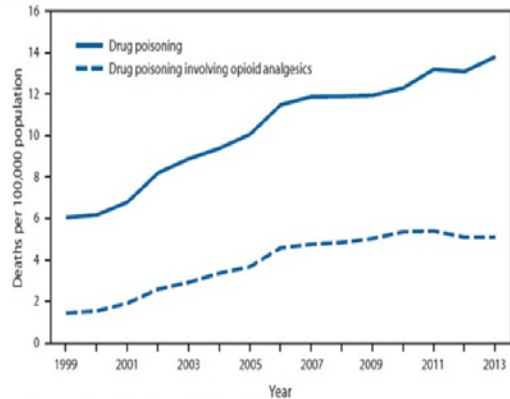
Andrew Fenelon, Senior Service Fellow in the National Center for Health Statistics at the Center for Disease Control. (@andyfenelon)

Robert Hummer, professor of sociology at the University of North Carolina.

Tyson Brown, professor of sociology at Vanderbilt University. (@tysonbrown)

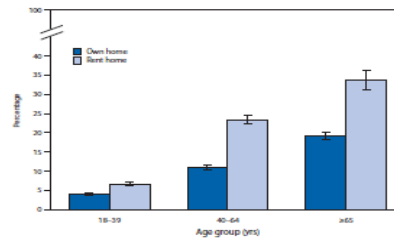
Spotlight on emerging issues, data needs

QuickStats: Rates of Deaths from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics— United States, 1999–2013



Chen LH, Hødegaard H and Warner M. QuickStats: Death rates for Drug Poisoning, and Drug Poisoning Involving Opioid Analgesics, United States, 1999–2013. January 16, 2015. MMWR 64(01); 32.

Percentage* of Adults with Fair or Poor Health,† by Home Ownership Status‡ and Age Group — National Health Interview Survey,§ United States, 2014

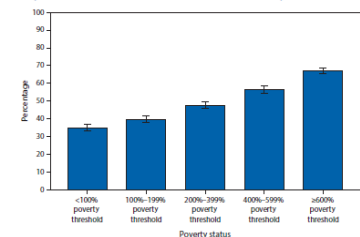


* With 95% confidence intervals indicated with error bars.
 † Defined by family respondent's answer to the following question on the family core questionnaire: "Would you say (your) health in general is excellent, very good, good, fair, or poor?"
 ‡ Defined by family respondent's answer to the following question on the family core questionnaire: "Is this house/apartment owned or being bought, rented, or occupied by some other arrangement by (you or someone in your family)?"
 § Estimates are based on household interviews of a sample of the noninstitutionalized U.S. civilian population and are derived from the National Health Interview Survey family core component.

In 2014, 7% of renters aged 18–39 years assessed their health as fair or poor compared with 4% of homeowners. Among adults aged 40–64 years, 23% of renters reported fair or poor health compared with 11% of homeowners. Among adults aged ≥65 years, 34% of renters reported fair or poor health compared with 19% of homeowners. For both renters or homeowners, the percentage of adults with fair or poor health increased with increasing age.

Source: National Health Interview Survey, 2014 data. <http://www.cdc.gov/nchs/nhisa.htm>.
 Reported by: Patricia C. Lloyd, PLloyd@cdc.gov; 301-458-4420; Veronica E. Hales.

Percentage* of Adults Who Met Federal Guidelines for Aerobic Physical Activity,† by Poverty Status‡ — National Health Interview Survey, United States, 2014§



* With error bars indicating 95% confidence interval.
 † Per U.S. Department of Health and Human Services 2008 Physical Activity Guidelines for Americans (<http://www.health.gov/pag/guidelines/guidelines-detail.aspx>). Respondents were considered to be meeting aerobic activity guidelines if they reported moderate-intensity physical activity for ≥150 minutes leisure-time activity per week, vigorous-intensity physical activity for ≥75 minutes leisure-time activity per week, or an equivalent combination of moderate-intensity and vigorous-intensity leisure-time activity.
 ‡ Poverty status is based on family income and family size using the 2013 U.S. Census Bureau poverty thresholds. Family income was imputed where missing.
 § Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population and are derived from the National Health Interview Survey sample adult component.

In 2014, the percentage of adults aged ≥18 years who met federal guidelines for aerobic physical activity increased as family income increased. The percentage of adults aged ≥18 years who met federal guidelines for aerobic physical activity ranged from 34.8% for those with family incomes <100% of the poverty level to 66.8% for those with family incomes ≥600% of the poverty level.

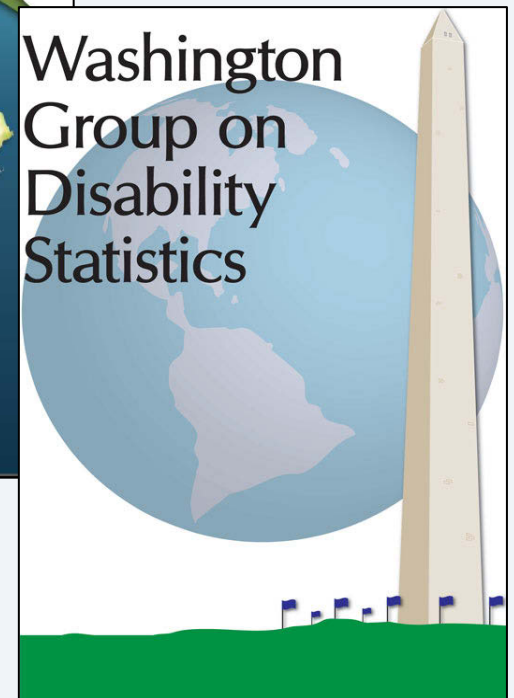
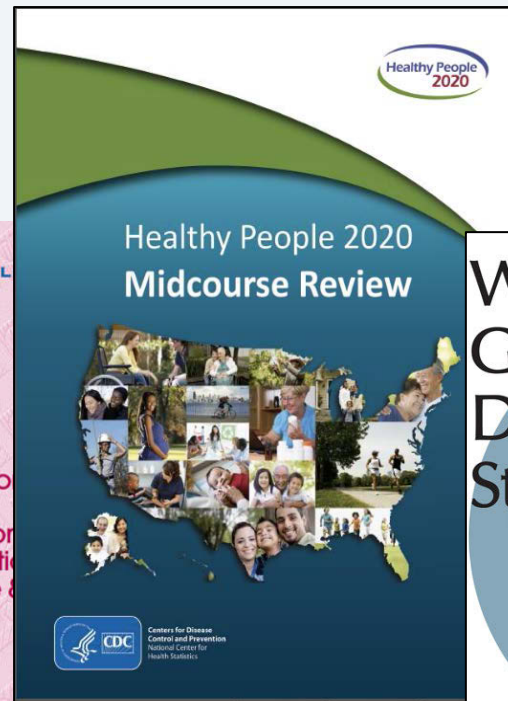
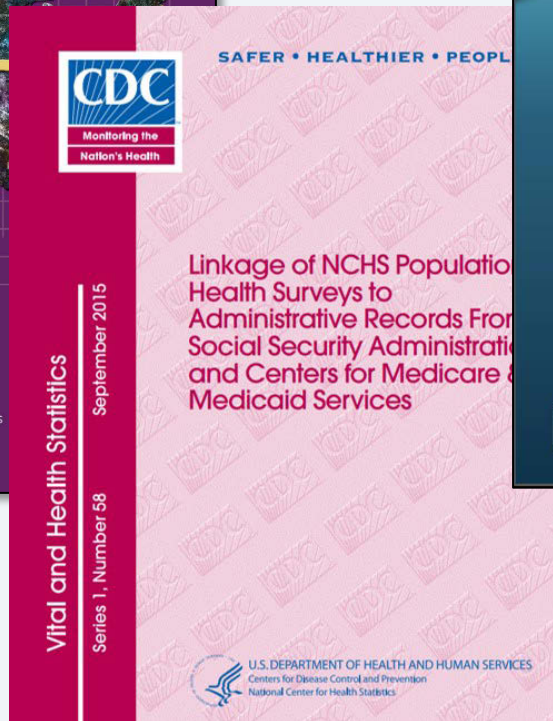
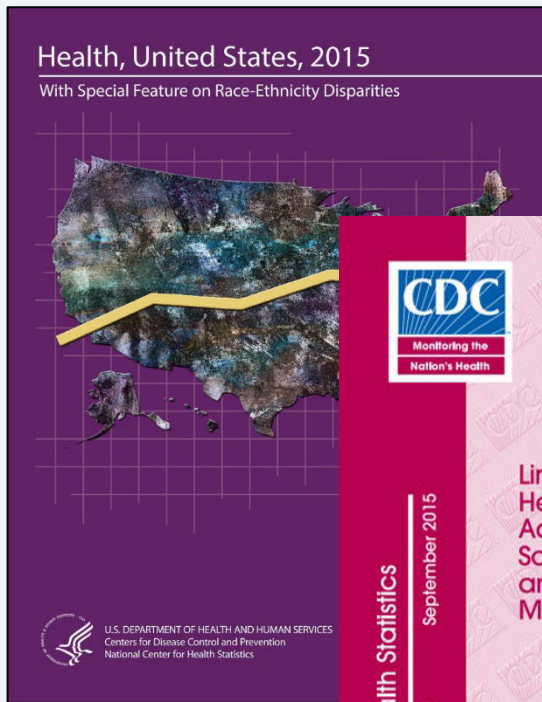
Source: National Health Interview Survey data, 2014. <http://www.cdc.gov/nchs/nhisa.htm>.

Reported by: LaKeana Hawkins, MPH, LD@kwnhsa.cdc.gov; 301-458-4611; Mark Montgomery, MS; Deepthi Kandl.

Establishing Priorities, Aligning Resources

- Long-standing, core activities that directly fulfill our statistical agency mission.
- Programmatic and time sensitive commitments and mandates that we must balance with our desire for unlimited innovation.
- Niche areas, specialized segments of the market where, right now, the agency is well positioned and can/desires to remain so.

Honoring long-standing commitments that fulfill NCHS' mission, and position us for the future



Understanding health disparities and progress toward reducing them

The Annals of Applied Statistics
2015, Vol. 9, No. 1, 992–1023
DOI: 10.1214/15-AAS0027
In the Public Domain

EXAMINING SOCIOECONOMIC HEALTH DISPARITIES USING A RANK-DEPENDENT RÉNYI INDEX

BY MAKRAM TALIH

National Center for Health Statistics

The Rényi index (RI) is a one-parameter class of indices that summarize health disparities among population groups by measuring divergence between the distributions of disease burden and population shares of these groups. The rank-dependent RI introduced in this paper is a two-parameter class of

The screenshot shows the CDC website interface. The main heading is 'Vintage 2014 Bridged-Race Postcensal Population Estimates'. Below the heading, there is a note: 'NOTE: The U.S. Census Bureau annually releases unbridged population estimates for five-year age groups and race at the county level. The Census Bureau does not release bridged-race or unbridged estimates by single-year of age at the county level due to concerns about the reliability of these estimates. However, these estimates are provided to the National Center for Health Statistics to meet programmatic needs by the Census Bureau should carefully consider the use of these estimates.' There are also links for 'File documents' and 'Download'.

1. Introducing health data elsewhere [H. Krieger, W. Wilson (2009) to address the supplement U.S. Healthy dressing the four overarching more good improve the health of all groups" (DHHS (2014)).

Received November 2014; revised February 2015.
Key words and phrases: Social welfare function, concentration c
cal inference, complex survey data, health surveillance data.

992

Int J Public Health (2015) 60:609–617
DOI 10.1007/s0003-015-0666-7

ORIGINAL ARTICLE



Mortality among US-born and immigrant Hispanics in the US: effects of nativity, duration of residence, and age at immigration

Julia S. Holmes · Anne K. Driscoll · Melanie Heron

Received: 30 October 2014 / Accepted: 29 April 2015
© Swiss School of Public Health (outside the I

ORIGINAL RESEARCH



Disparities in Temporal and Geographic Patterns of Declining Heart Disease Mortality by Race and Sex in the United States, 1973–2010

Adam S. Vaughan, MPH, MSc, Harrison Quirk, PhD, Elizabeth B. Petruk, PhD, Michael R. Kramer, PhD, Michelle Capoor, PhD

Background—Examining spatio-temporal differences in the strength of declining heart disease mortality by race and sex provides important context for current racial and geographic disparities and identifies localities that could benefit from targeted interventions. We identified and described temporal trends in declining county-level heart disease mortality by race, sex, and geography between 1973 and 2010.

Methods and Results—Using a Bayesian hierarchical model, we estimated age-adjusted mortality with diseases of the heart listed as the underlying cause for 3,099 counties. County-level percentage declines were calculated by race and sex for 3 time periods (1973–1985, 1986–1997, 1998–2010). Strong declines were statistically faster or no different than the total national decline in that time period. We observed county-level race-sex disparities in heart disease mortality trends. Continual (from 1973 to 2010) strong declines occurred in 73.2%, 44.6%, 15.5%, and 17.3% of counties for white men, white women, black men, and black women, respectively. Delayed (1998–2010) strong declines occurred in 15.4%, 42.0%, 75.5%, and 76.6% of counties for white men, white women, black men, and black women, respectively. Counties with the weakest patterns of decline were concentrated in the South.

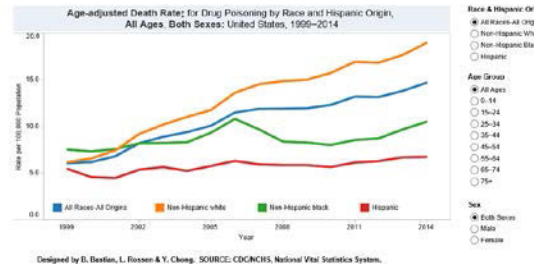
Conclusions—Since 1973, heart disease mortality has declined substantially for these race-sex groups. Patterns of decline differed by race and geography, reflecting potential disparities in national and local drivers of these declines. Better understanding of racial and geographic disparities in the diffusion of heart disease prevention and treatment may allow us to find clues to progress toward racial and geographic equity in heart disease mortality. (*J Am Heart Assoc.* 2015;4:e002567 doi: 10.1161/JAHA.115.002567)

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Rethinking the Hispanic Paradox: The Mortality Experience of Mexican Immigrants in Traditional Gateways and New Destinations

Andrew Fenelon

Previous research suggests that favorable health outcomes among Mexican immigrants reflect high levels of social support in enclave communities with high ethnic density. This study examines the mortality outcomes of Mexican immigrants in the United States in traditional gateways versus new and minor destinations. Mexican immigrants in new and minor destinations have a significant survival advantage over those in traditional gateways, reflecting less established communities in new destinations. This finding casts doubt on the protective effects of enclaves, since non-traditional destinations have less-established immigrant communities. Future research should reevaluate the relationship between community ethnic composition, social support, and immigrant health.



Designed by D. Bastian, L. Rossen & Y. Chang. SOURCE: CDC/NCHS, National Vital Statistics System.

NOTES:
† Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD-10). Drug-poisoning deaths are defined as having ICD-10 underlying cause of death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent).
‡ Estimates are based on the National Vital Statistics System multiple cause-of-death mortality files (1). Age-adjusted death rates (deaths per 100,000 U.S. standard population for 2000) are calculated using the direct method. Populations used for computing death rates for 2011–2014 are postcensal

The Future: Challenges ...

- Changes in budget, staffing, organization
 - Retirements and departures
 - Relocating to new space
- Center priorities, some new, some ongoing
 - Rethinking our approach to data access tools
 - Sunsetting (for now) of products, programs
- Realignment
 - Reorientation toward Center-centric work
 - Repositioning of Staff

And Opportunities

- Staffing: New staff brings new opportunities
 - Sibeso Joyner, Analyst, Health Promotion Statistics Branch (HPSB)
 - Elizabeth Pathak, Methodologist, HPSB
 - Mark Montgomery, Student Volunteer, TBA HPSB
 - Lisa Mirel, Chief, Special Projects Branch
 - Ernest Moy, Senior Medical Officer, OAE Office of the Director
- Long standing programs face important transitions
 - New data sources (electronic health records, administrative data)
 - New ways to access our data (API, user friendly interfaces, tweets)
 - Anniversaries as time for thinking of the future (Health, US; Healthy People)
 - Engaging in strategic thinking about our research: cross-OAE, cross-NCHS