# PROGRESS REVIEW

## Surveillance and Data Systems

**DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ February 18, 1997**

The Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion) and the HHS Principal Deputy Assistant Secretary for Planning and Evaluation jointly chaired a review of progress on objectives for surveillance and data systems. This briefing commenced the third round in the on-going series of reviews covering the 22 priority areas of HEALTHY PEOPLE 2000. Progress on the 7 objectives in priority area 22 is described below.

***22.1*** Eighteen health status indicators (HSI) were established in 1991. These include 9 mortality measures, 3 birth indicators, 4 infectious disease rates, and 2 other indicators. Fifty States and the District of Columbia were monitoring some HSI's in 1993; the year 2000 target of 40 States has been met. Thirty-six States were providing HSI data to local health departments in 1992. The target is 40. National data for HSI's are published annually in the *Healthy People 2000 Review* by race and Hispanic origin. State HSI data can be found on the World Wide Web through the National Center for Health Statistics home page (http://www.cdc.gov/nchswww/nchshome.htm).

***22.2*** In the baseline year 1990, 77 percent of year 2000 national health objectives had data sources to measure progress. In 1996, 98 percent had such sources. Since there are no baselines and no plans for data collection for 7 of the 319 objectives, the year 2000 target of 100 percent has effectively been achieved. In addition, 74 percent of the objectives now have at least one update. In 1997, State year 2000 plans had been published by 44 States, the District of Columbia and Guam. The target is 50 States.

***22.3*** Twenty-one percent of Federal, State and local agencies in 1994 collected comparable data for selected year 2000 objectives, an increase from 12 percent in baseline year 1990. The year 2000 target is 100 percent. Objectives monitored with the National Vital Statistics System, the Youth Risk Behavior Survey, the Notifiable Disease Surveillance System, and the Fatal Accident Reporting System are based on State data. Objectives monitored with the National Health Interview Survey were also counted if the State Behavioral Risk Factor Surveillance System included comparable questions.

***22.4*** Identifying significant gaps in the Nation's disease prevention/health promotion data is an on-going process. Through the midcourse review, 111 new special population subobjectives were added because of new data becoming available that identified health disparities.

### HIGHLIGHTS

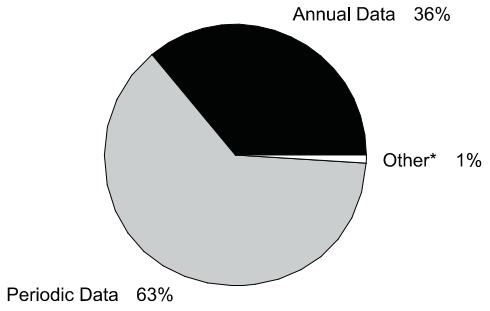
- In 1996, 8 percent of the 319 unduplicated Healthy People 2000 objectives had reached or surpassed their targets; 40 percent had progressed toward the targets; 18 percent showed movement away from the target; 5 percent showed mixed results; and 3 percent showed no change from the baseline. Seventy-five objectives (20 percent) have baseline data but no new data with which to evaluate progress. Baselines have yet to be obtained for 19 objectives (6 percent).
- Data are now available to provide annual updates on 36 percent of the Healthy People 2000 objectives. Another 63 percent of the objectives can be updated periodically.
- The Health Insurance Portability and Accountability (Kennedy-Kassebaum) Act of 1996 is expected to provide a major impetus for new electronic data transmission standards and for data linkage and integration.
- The electronic birth record has accelerated the flow of data from hospitals through States to the National Center for Health Statistics.

***22.5*** This objective measures the results of State data collection efforts. The year 2000 target for vital statistics data was met by the 1989 baseline of 50 States plus the District of Columbia. Since 1994, all States have conducted a Behavioral Risk Factor Survey. The number of States collecting and publishing hospital discharge data increased from 22 in 1989 to 29 in 1996. For Youth Risk Behavior Survey data, there was an increase from 24 States in 1989 to 43 in 1993, and a subsequent decline to 40 in 1995. In 1996, 22 States analyzed and published data on their progress toward the national or State-specific objectives for each racial or ethnic group making up at least 10 percent of the State population. The baseline was 19 States in 1992 and the year 2000 target is 25.

***22.6*** The year 2000 target for electronically transferring information related to the national health objectives among Federal, State and local agencies has been met. The National Electronic Telecommunications System for Surveillance has provided weekly data on cases of nationally notifiable diseases to the Centers for Disease Control and Prevention since 1989. The Public Health Laboratory Information System has been used in all States since 1994 to share data for epidemiologic, laboratory, survey, case-control and most other public health data needs. DATA2000, available to all Internet users, is an electronic database containing the national baseline and monitoring data for each Healthy People 2000 objective and special population subobjective, as well as the Health Status Indicators.

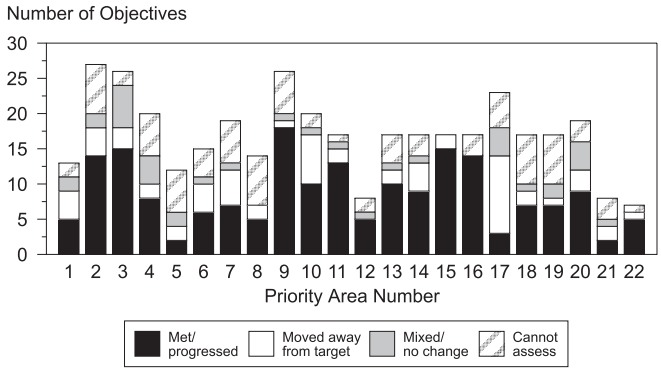
***22.7*** Timeliness in the release of national surveillance and survey data reflects the proportion of objectives that have updates for a particular year. This proportion varies with the periodicity of data collection mechanisms. Progress has been made in releasing preliminary data from the National Vital Statistics System within 1 year of collection instead of the 2 years it has taken in the past.

## Periodicity of Healthy People 2000 Data Sources




Source: CDC/NCHS, Division of Health Promotion Statistics
*Objectives considered to be met and no longer tracked

## Summary of Progress by Priority Area




Source: CDC/NCHS, Division of Health Promotion Statistics.
IN Healthy People 2000 Review, 1995-96, Figure 1, P.1.

## FOLLOW-UP

- Involve State and local governments at every stage of national data collection, analysis and dissemination. Approaches to this include—adding questions to existing national surveys rather than creating new surveys; oversampling special population groups; designing and conducting surveys that measure interventions; developing a data collection mechanism that can be utilized by multiple levels of government.
- Translate national data sets into more user-friendly forms for States and communities. Employ means such as—increasing access to publications through electronic media; increasing availability of data through the Internet and CD-ROM; communicating with State health departments regarding forthcoming data releases. Apply geocoding to national health surveys, vital statistics reporting, the Behavioral Risk Factor Surveillance System, and Hospital Discharge data sets.
- Provide technical assistance to the 500+ Indian tribal governments to enhance their capacity to collect health-related data.
- Examine linkages between socio-economic status and health risks to give a more complete picture of the effects of poverty on health.
- Collaborate with the private sector to scale their information to the community level. In addition, ensure that community-level public health data are available to private health care providers.
- Explore the feasibility of establishing a data collection block grant or setting aside a portion of the block grants for data activities.
- Proactively address confidentiality requirements to ensure the integrity of all data collection activities.
- Achieve greater coordination and pooling of data resources across agency lines within DHHS to strengthen the Department's data activities. In addition, achieve better linkages between census data and other program data.
- In developing health promotion/disease prevention objectives for 2010, give greater attention to State and local priorities. Consider identifying these as an adjunct to the national objectives.

## FOLLOW-UP (cont'd)

- Monitor the impact on the collection of survey data of the Congressional mandate to reduce the Federal reporting burden by 25 percent over the next 3 years.

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Health Care Financing Administration
Health Resources and Services Administration
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Minnesota Department of Health
National Committee on Quality Assurance
National Institutes of Health
Office of the Assistant Secretary for Management and Budget
Office of the Assistant Secretary for Planning and Evaluation
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