



The Federal Statistical System

What is a federal statistical agency?

The U.S. federal statistical system is composed of the 13 principal federal statistical agencies (see Figure), each of which has a principal mission to produce a substantial portion of official federal statistics. The Office of Management and Budget's (OMB) Office of Information and Regulatory Affairs (OIRA) coordinates the nation's decentralized federal statistical system through the Interagency Council on Statistical Policy (ICSP), which enables the exchange of information about statistical programs and activities. Within this system, the National Center for Health Statistics (NCHS) functions as the federal agency responsible for the collection and dissemination of the nation's vital and health statistics.

Federal statistical agencies are charged with providing relevant, accurate, and timely data to inform public and private decision making. To meet this charge, agencies rely on the *Principles and Practices for a Federal Statistical Agency* developed by the National Research Council (NRC) of the National Academies to guide their strategic planning, daily operations, and interactions with stakeholders. Agencies embrace a common set of professional standards and operational practices designed to ensure the quality, integrity, and credibility of their statistical activities. This allows them to provide objective information that is relevant to issues of public policy. Independence is key to maintaining the trust of those who provide and use the information. Actual or perceived violations of any of these principles undermines the scientific integrity of, and public confidence in, the data produced by principal statistical agencies.

Current U.S. federal statistical system



About NCHS

NCHS is the nation's principal health statistics agency, providing data to identify and address health issues. NCHS compiles statistical information to help guide public health and health policy decisions.

Secretarial designation

By statute, the NCHS director is appointed by the Secretary of the Department of Health and Human Services (HHS). While the NCHS director reports to the Centers for Disease Control and Prevention (CDC) regarding NCHS operations, the director reports directly to the Secretary of HHS as a senior advisor on health statistics. The NCHS director is co-chair of the HHS Data Council, which is the principal advisory body to the Secretary on health and human services data policy.



Statistical policy directives: OMB has issued several statistical policy directives to guide statistical agencies and to ensure that federal statistics are objective, credible, relevant, accurate, and timely. Two of the most important are:

▪ **Directive 1: Fundamental responsibilities of federal statistical agencies and recognized statistical units (trust directive)**—Provides a framework that supports federal statistical policy, serves as a foundation for federal statistical activities, and calls on HHS to enable, support, and facilitate NCHS as it implements four core responsibilities to:

- produce and disseminate relevant and timely information;
- conduct credible and reliable statistical activities;
- protect the trust of data providers by ensuring the confidentiality and exclusively statistical use of their data; and
- conduct objective statistical activities.

▪ **Directive 4: Release and dissemination of statistical products produced by federal statistical agencies**—Establishes requirements for equitable access to and transparency on the release and dissemination of statistical products.

OMB directives in practice

- NCHS must avoid even the *appearance* that the design, collection, processing, editing, compilation, storage, analysis, release, and dissemination of data may be manipulated or influenced by those outside of NCHS.
- NCHS has autonomy in determining the timing and release of statistical products. HHS and CDC leadership do not influence the dates when statistical products will be released. In addition, NCHS releases public-use data files as soon as they are ready for dissemination.
- NCHS provides extensive information about how the data were collected and any known or potential data limitations or sources of error; ensures that all users, including those internal to HHS and CDC, have equitable access to the data at the same time; and maintains safeguards to protect the integrity and confidentiality of the data.

As a statistical agency, NCHS does not make policy recommendations in reports and publications and these products must be free from any perceived or actual partisan intervention. Instead, NCHS provides the high-quality data that inform the development of policy. Like all federal statistical agencies, NCHS adheres to high standards of objectivity, fostering public trust in the quality and credibility of the data in its statistical publications. In addition, the Confidential Information Protection and Statistical Efficiency Act provides strong protection for information that is obtained for exclusively statistical purposes under a pledge of confidentiality.

Vitalsigns™
 Opioid overdoses went up 30% from July 2016 through September 2017 in 52 areas in 45 states.
 The Midwest region saw opioid overdoses increase 70% from July 2016 through September 2017.
 Opioid overdoses in large cities increased by 54% in 16 states.

Opioid Overdoses Treated in Emergency Departments
 Identify opportunities for action
 Emergency department (ED) visits for opioid overdoses rose 30% in all parts of the US from July 2016 through September 2017. People who have had an overdose are more likely to have another, so being seen in the ED is an opportunity for action. Repeat overdoses may be prevented with medication-assisted treatment (MAT) for opioid use disorder (OUD), which is defined as a problematic pattern of opioid use. EDs can provide naloxone, link patients to treatment and referral services, and provide health departments with critical data on overdoses. EDs provide an early warning system for health departments to identify increases in opioid overdoses more quickly and coordinate response efforts. This fast-moving epidemic does not stay within state and county lines. Coordinated action between EDs, health departments, mental health and treatment providers, community-based organizations, and law enforcement can prevent opioid overdose and death.

Health departments can:

- Alert communities to rapid increases in overdoses seen in EDs for an informed and timely response.
- Increase naloxone distribution (an overdose-reversing drug) to first responders, family and friends, and other community members in affected areas, as policies permit.
- Increase availability of and access to treatment services, including mental health services and MAT for OUD.
- Support programs which reduce harms from injecting opioids, including those offering screening for HIV and hepatitis B and C, in combination with referral to treatment.
- Support the use of the CDC Guideline for Prescribing Opioids for Chronic Pain, which encourages using prescription drug monitoring programs (PDMPs) to inform clinical practice. <https://go.usa.gov/nv9u0>

Options include prescription pain medications, heroin, and illicitly manufactured fentanyl.

Centers for Disease Control and Prevention
 National Center for Injury Prevention and Control

- Health departments can:**
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 - Increase naloxone distribution (an overdose-reversing drug) to first responders, family and friends, and other community members in affected areas, as policies permit.
 - Increase availability of and access to treatment services, including mental health services and medication-assisted treatment for opioid use disorder.
 - Support programs which reduce harms from injecting opioids, including those offering screening for HIV and hepatitis B and C, in combination with referral to treatment.
 - Support the use of the CDC Guideline for Prescribing Opioids for Chronic Pain, which encourages using prescription drug monitoring programs to inform clinical practice.

While the rest of CDC may offer recommendations, NCHS must only provide objective statistical descriptions of data.

NCHS Vital Statistics Rapid Release
 Provisional Drug Overdose Death Counts

CDC • NCHS • National Vital Statistics System • Vital Statistics Rapid Release • Surveillance Activities

Provisional Drug Overdose Death Counts

This data visualization presents provisional counts for drug overdose deaths based on a current flow of mortality data in the National Vital Statistics System. Counts for the most recent final annual data are provided for comparison. National provisional counts include deaths occurring within the 50 states and the District of Columbia as of the date specified and do not include all deaths that occur during a given month. Provisional counts are often incomplete and causes of death may be pending investigation (see Technical notes) resulting in a need relative to final counts. To address this, methods were developed to adjust provisional counts for reporting delays by generating a provisional count (see Technical notes).

The provisional data presented in this visualization include: 1) all reported and predicted provisional counts of deaths due to drug overdose occurring nationally and jurisdiction; 2) a 15% drop of the percentage change in provisional drug overdose deaths for the 12-month period ending per compared with the 12-month period ending in the same month of the previous year, by jurisdiction; and 3) all predicted provisional counts of drug overdose deaths involving specific drugs or drug classes occurring nationally and in selected reported and predicted provisional counts represent the number of deaths due to drug overdoses occurring in the 12-month period month indicated. These counts include all seasons of the year and are insensitive to variations by seasonality. Deaths are reported jurisdiction in which the death occurred.

Several data quality metrics, including the percent completeness in overall death reporting, percentage of deaths with cause of death further investigation, and the percentage of drug overdose deaths with specific drugs or drug classes reported are included to aid of provisional data as these measures are related to the accuracy of provisional counts (see Technical notes). Reporting of the exact drug classes involved in drug overdose deaths varies by jurisdiction, and comparisons of death rates involving specific drugs across jurisdictions should not be made (see Technical notes). Provisional data presented in this visualization will be updated on a monthly additional records are received.

Figure 18. Percent Change in Predicted 12-Month-Ending Count of Drug Overdose Deaths, by Jurisdiction, February 2017 to February 2018

Select profit or nonprofit number of predicted Reported

Percent Change United States

Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

NOTE: Provisional provisional counts for 12-month ending periods are the number of deaths reported and processed for the 12-month period ending in the month. The reported deaths are other deaths reported with a cause of death pending investigation. These are reported monthly, increasing monthly by the number of deaths reported. Provisional provisional counts represent estimates of the number of deaths subject to incomplete reporting (see Technical notes). Deaths are classified by the reporting jurisdiction in which the death occurred. Provisional drug rates in the report are affected because the number of deaths due to drug overdose occurring in the 12-month period ending in the month indicated compared with the 12-month period ending in the same in previous year. Drug overdose deaths are identified using ICD-10 underlying cause-of-death codes: CDC codes: 430-434, 438, and V10-114.

Key findings

- In 2017, there were 70,237 drug overdose deaths in the United States.
- The age-adjusted rate of drug overdose deaths in 2017 (21.7 per 100,000) was 9.6% higher than the rate in 2016 (19.8).
- Adults aged 25–34, 35–44, and 45–54 had higher rates of drug overdose deaths in 2017 than those aged 15–24, 55–64, and 65 and over.
- West Virginia (57.8 per 100,000), Ohio (46.3), Pennsylvania (44.3), and the District of Columbia (44.0) had the highest age-adjusted drug overdose death rates in 2017.
- The age-adjusted rate of drug overdose deaths involving synthetic opioids other than methadone (drugs such as fentanyl, fentanyl analogs, and tramadol) increased by 45% between 2016 and 2017, from 6.2 to 9.0 per 100,000.

On This Page: Dashboard, Data Tables for Current Dashboard, Technical notes

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Drug Overdose Deaths in the United States, 1999–2017

Holly Hodgson, M.D., Aralim M. Minofo, M.P.H., and Margaret Warner, Ph.D.

Key findings

Data from the National Vital Statistics System, Mortality

In 2017, there were 70,237 drug overdose deaths in the United States.

The age-adjusted rate of drug overdose deaths in 2017 (21.7 per 100,000) was 9.6% higher than the rate in 2016 (19.8).

The age-adjusted rate of drug overdose deaths increased from 6.1 per 100,000 standard population in 1999 to 21.7 in 2017. The rate increased

Deaths from drug overdoses continue to be a public health burden in the United States (1). This report uses the most recent final mortality data from the National Vital Statistics System (NVSS) to update trends in drug overdose deaths, describe demographic and geographic patterns, and identify shifts in the types of drugs involved.

In 2017, the age-adjusted rate of drug overdose deaths in the United States was 9.6% higher than the rate in 2016.

- In 2017, there were 70,237 drug overdose deaths in the United States (Figure 1).
- The age-adjusted rate of drug overdose deaths in 2017 (21.7 per 100,000) was 9.6% higher than the rate in 2016 (19.8).
- The age-adjusted rate of drug overdose deaths increased from 6.1 per 100,000 standard population in 1999 to 21.7 in 2017. The rate increased

Figure 1. Age-adjusted drug overdose death rates—United States, 1999–2017

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