Submission
for
The Framingham Study, NHLBI

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The Framingham Study

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Supporting Statement

A. Justification

A.1. Circumstances Making the Collection of Information Necessary

The objective of this information collection is within the National Heart, Lung, and Blood Institute (NHLBI) mandate described in the Public Health Service Act, Section 421 (42 USC 285b-3) and specifies the provision of "investigation into the epidemiology, etiology and prevention of all forms and aspects of heart, blood vessel, lung and blood diseases, including investigations into the social, environmental, behavioral, nutritional, biological and genetic determinants and influences involved in the epidemiology, etiology and prevention of such diseases."

Cardiovascular disease is a major public health concern because it is the leading cause of death and a major source of illness and disability. It has an adverse effect on the quality of life of patients and their families. Cardiovascular disease is the underlying cause of death for 37% of all deaths in the U.S. Other measures of the public health importance of cardiovascular disease are the major burdens it imposes on health care personnel, medical institutions and resources. One of the roles of the NHLBI, Division of Prevention and Population Studies (DPPS) is to plan and direct epidemiological studies and projects for disease prevention, and health promotion in heart diseases. The Framingham Heart Study is one of many ongoing studies that help to fulfill that role and address the public health concerns described above.

Despite substantial progress in understanding of pathological precursors of cardiovascular disease, there still exists a compelling need to utilize the prospective epidemiological design to improve methods of identifying the high risk individual at the youngest possible age. Over the last six decades, The Framingham Study has made major contributions to the knowledge and utility of cardiovascular disease risk factors. Beginning with the first paper in the 1950s that identified serum cholesterol, cigarette smoking, blood pressure and left ventricular hypertrophy as "factors of risk," The Framingham Heart Study has expanded the scope and nature of cardiovascular risk factors. For example, because of protocol enhancements that permitted

measurement of lipoprotein cholesterol beginning in 1969 in the original cohort and in 1971 in the offspring cohort, the limited scope of total cholesterol has been expanded to a more useful lipoprotein profile that includes knowledge of LDL-C and HDL-C as well as total cholesterol. The nature of the risk factors shown to be associated with cardiovascular disease has changed as technological development has presented new opportunities to study cardiac structure with non-invasive methods. For example, after The Framingham Heart Study protocol included echocardiography in 1979, only four years of follow-up were necessary to demonstrate a strong relationship between left ventricular mass and the incidence of cardiovascular disease.

Despite the rapid increase in knowledge about the etiology of cardiovascular disease that has resulted from these studies, there remain numerous opportunities to improve the identification of high risk individuals. There is also a need to better understand the details of the mechanisms of cardiovascular pathophysiology for two reasons: (1) because earlier, more effective treatments might result from improved knowledge of mechanisms and (2) because good information about mechanistic connections between personal behavior and disease processes may increase the likelihood of beneficial behavior changes. Finally, there is a need to monitor all aspects of cardiovascular status in this genetically circumscribed sample over time.

A.2. Purpose and Use of the Information

The purpose of this information collection for The Framingham Heart Study is to continue to collect medical and lifestyle information on a long-term cohort in order to pursue the objectives described above. There are three existing study cohorts which comprise the Framingham Study. These are the Original Cohort (originating in 1948), the Offspring Cohort (children of the Original Cohort and their spouses, originating in 1971), and the Generation Three Cohort (children of the Offspring Cohort, originating in 2002). This proposal is to extend the

Framingham Study to re-examine the Original Cohort, to re-examine the Generation Three Cohort, to conduct a computerized tomography (CT) examination of the Offspring Cohort, and to continue to monitor the morbidity and mortality which occurs in all three Framingham Cohorts. The contractor, with the collaborative assistance of NHLBI staff, will invite study participants, schedule appointments, administer examinations and testing, enter information into computer terminals for editing, and prepare scientific reports of the information for publication in appropriate scientific journals. All participants have been examined previously and thus the study deals with a stable, carefully described group.

Data is collected in the form of a health examination involving such components as blood pressure measurements, venipuncture, electrocardiography and a health interview, including questions about lifestyles and daily living situations. The data collection instruments for re-examination of the Original Cohort and for re-examination of the Generation Three are attached. Describing and determining the etiology of coronary heart disease is a dynamic science that changes over time as new risk factors are identified and methods of diagnosis and treatment are improved.

Some additional data collection efforts do not apply to the entire population participating in each examination. There may be collection of DNA and cell lines samples from Generation Three Cohort participants whose current samples are missing, depleted or inadequate. Subsamples of the Generation Three will have computed tomography of the abdomen and thigh for measurement of fat depots and to study the relation of body composition to risk for cardiovascular disease. Furthermore, individuals who are either unwilling or unable to participate in an examination are sent Health Status Update Forms (form attached.) The National Heart, Lung, and Blood Institute uses the results of The Framingham Heart Study to

1) characterize risk factors for cardiovascular and lung diseases so that national prevention programs can be designed and implemented; 2) evaluate trends in cardiovascular diseases and risk factors over time to measure the impact of overall preventive measures; and 3) understand the etiology of cardiovascular and lung diseases so that effective treatment and preventive modalities can be developed and tested.

Most of the reports of study results have been published in peer reviewed medical journals and books. The majority of these publications have appeared in the cardiology or cardiovascular epidemiology literature. One recent report, which appeared in the New England Journal of Medicine combined 55 years of data from the Original Cohort with 20 years of data from the Offspring Cohort to examine the association of parental heart failure with risk of heart failure in the offspring. The investigators found that, after adjustment for covariates, having a parent with heart failure increased the risk of heart failure in the offspring by about 70 percent. They estimated that the population attributable risk for heart failure due to the presence of the condition in a parent was about 18 percent.

More than 1600 articles have been published from The Framingham Study since 1952. The previous OMB submission contains a listing of articles published from 2000-2004. Framingham Heart Study articles published during 2005-2007 are listed in the attached files. The variety of titles in the listing suggest the wide range of hypotheses that have been tested using data collected at previous cohort, offspring, and third generation examination cycles. The results of Framingham Heart Study will continue to be published by the contractor and NHLBI staff in scientific and medical literature. Results which will appear in the literature will continue to be used by the medical community to improve their understanding of the mechanisms of cardiovascular diseases as they occur in a general population setting. Their understanding will

help health care providers treat patients by recommending preventive measures for future disease among healthy individuals, as well as those with cardiovascular disease. This information also will be used by the Federal government and health professionals to design and target cardiovascular disease prevention and education program

A.3. Use of Information Technology and Burden Reduction

The Framingham Study will use state-of-the-art data entry and computer management systems which maximize data accuracy. Data from anthropometric measurements, blood pressure, questionnaires, and venipuncture collection and processing will be recorded on paper forms by clinic personnel and then key entered into the database. Electrocardiographic, computed tomography, ultrasound, tonometry, and pulmonary function data will be collected electronically on separate, procedure-dedicated computers.

A.4. Efforts to Identify Duplication and Use of Similar Information

There is no duplication of effort because the Original Cohort, Offspring Cohort, and Third Generation Cohort are unique. No other study of free-living adults has a comparable database on the cardiovascular experience of parents and offspring. No other group of free-living adults has been so extensively tested using non-invasive cardiology methods because these methods are usually applied to symptomatic patients. No other large group of parents, children, and grandchildren has undergone longitudinal studies of risk factor quantification. Because of the dynamic features of cardiovascular diseases, it is necessary to update previous findings related to earlier examinations and assess the consequences of the collected information from prior examinations in terms of the impact on cardiovascular disease incidence. A key feature of the Framingham Heart Study is that it is monitoring the same community-based sample over time. This will permit an assessment of secular trends in cardiovascular disease that are not likely to

be biased by changes in sample composition over time.

The NHLBI supports a study titled The Atherosclerotic Risk in Communities (ARIC) Study (OMB# 0925-0281, expiration date 5/31/10). This study, however, is different from the Framingham Study because The ARIC Study is measuring different risk factors while using different approaches to assessing cardiovascular disease status. Furthermore, there is a community surveillance and cohort linkage unique to The ARIC Study, which will increase the ability to study cardiovascular disease.

Since cardiovascular disease is a dominant health problem among older populations, the NHLBI initiated The Cardiovascular Health Study (OMB# 0925-0334, expiration date 09/30/07-currently under OMB renewal review). This study of four elderly cohorts focuses on factors thought to induce clinically overt disease. It is designed to assess the prediction of clinical disease from non-invasive measures of preclinical disease such as carotid atherosclerosis, left ventricular impairment, and arrhythmias or transient ischemia. It will also assess the associations between clinical disease and recent changes in health or life circumstances such as concurrent disease, social support, stressful life situations, diet, physical activity and functional status.

The Family and Genetic Study of Cardiovascular Disease (Family Heart Study) Phase I (OMB #: 0925-0399, expiration date 01/31/96), Phase II (OMB #: 0925-0412, expiration date 01/31/97), and its follow-up cooperative agreement, were initiated to identify and evaluate genetic and non-genetic determinants of coronary heart disease, atherosclerosis and their risk factors in ongoing population based epidemiological studies. Specific objectives of this study include: 1) to develop and implement standardized methods for ascertaining and validating family histories of cardiovascular disease and related conditions, for measuring selected risk factors and detecting

clinical and pre-clinical evidence of coronary heart disease, and collecting, analyzing and storing blood for studies of genetic markers and candidate genes; 2) to examine first degree relatives from families with coronary heart disease and first degree relatives from a random sample of families of participants in ongoing studies; 3) to compare the distributions of genetic, behavioral, physical, biochemical and environmental risk factors, and preclinical disease in the two sets of families and in individuals with and without coronary heart disease or preclinical atherosclerosis; 4) to estimate the separate and combined contributions of genetic and environmental determinants to familial clustering of risk factors, atherosclerosis, and coronary heart disease. Although a subset of The Framingham Heart Study population contributes to one of the cohorts under study in The Family Heart Study, The Family Heart Study will not provide longitudinal genetic analyses and long-term follow-up available in The Framingham Study.

Each of these studies has its own particular strength and major focus. The dominant strength of The Framingham Heart Study is the long term follow-up and multi-generational design. A major focus of The Framingham Heart Study is the detailed cardiovascular and pulmonary assessment of each participant and the identification of the genetic contribution to disease.

There is no similar information available. The unique features of this study, described above, preclude the use of modification of similar data. The Framingham Heart Study will collect new information on the original cohort and their offspring. This information will further our understanding of the development of cardiovascular disease and will be used to recommend cardiovascular disease prevention approaches.

A.5. Impact on Small Businesses or Other Small Entities

Physicians, health care providers, and nursing homes constitute the only small businesses which may receive requests for information for this study. The study requests medical records

from participants= regular medical care providers such as private physicians and clinics in order to track medical events that occur in study participants. These requests are limited only to essential information needed to determine the presence of disease events. The response of these small businesses is only 40 minutes per event and the estimated number of events requiring inquiry is 900 per year throughout all of the three cohorts. The data collection forms have been reduced to the essential information necessary to validate the disease diagnoses. The study is dependent on this information because it is not readily or accurately available from any other sources. The participants= medical care providers have been responsive to these requests in the past and it is not anticipated that the current request will pose any problems for these respondents.

A.6. Consequences of Collecting the Information Less Frequently

The Original Cohort is currently being examined to complete Examination 29 by December 31, 2007 (OMB 0925-0216). The Offspring Cohort is currently being examined to complete Examination 8 by December 31, 2007. The Original Cohort has been scheduled for examinations every two years, a frequency required due to the high mortality at the current older ages. The second examination of the Generation 3 Cohort is planned to begin during the spring of 2008, six years following their first examination. Due to the dynamic features of cardiovascular disease, it is important to update previous findings related to the course of cardiovascular disease development. Furthermore, theories concerning mechanisms of disease development can be developed and will help describe revised approaches to cardiovascular disease prevention. The Framingham Study and its findings have left no doubt concerning the dynamic nature of cardiovascular disease. The continuation of The Framingham Heart Study is essential for describing how changes in lifestyle and metabolic factors are related to cardiovascular disease development.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

Two weeks prior to the Generation Three Cohort Exam 2 clinic visit, an appointment letter will be sent that includes a request for a list of medications and healthcare contacts and a dietary questionnaire which they are asked to complete and bring with them to the clinic. Collection of this information is required in advance of the clinic visit since medication names are more readily available in the home, names of health care contacts are available in the home, and the dietary questionnaire can be completed with fewer time constraints in the home.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside Agency

A Federal Register notice, wherein public and affected agencies= comments were solicited, was published on November 6, 2007. Two public comments were received, and are attached.

This study continuation was approved at a meeting of the National Heart, Lung, and Blood Advisory Council on June 13, 2006. A copy of the relevant minutes from this meeting and a roster of Council members are attached.

An executive committee meets regularly to advise on policy and operations. This committee addresses issues relating to data collection, clarity of instructions, record keeping, and frequency of collection. The members of this committee are:

Daniel Levy, M.D., Framingham Study, NHLBI, 508-935-3458

Philip Wolf, M.D., Boston University School of Medicine, 617-638-5450

Ralph D=Agostino, Ph.D., Boston University College of Liberal Arts, 617-353-2767

Emelia Benjamin, M.D., Boston University School of Medicine, 617-638-8468

Christopher O=Donnell, M.D., Framingham Study, NHLBI, 508-935-3435

Caroline Fox, M.D., Framingham Study, NHLBI, 508-935-3439

Vasan Ramachandran, M.D., Boston University School of Medicine, 503-935-3450

Paul Sorlie, Ph.D., DPPS, NHLBI, 301-435-0456

An Observation Studies Monitoring Board meets annually and advises the NHLBI regarding study progress and performance and on participant safety and privacy; the minutes are attached. The members are

Russell Luepker, M.D., University of Minnesota, Division of Epidemiology, 612-624-6362

Philip Greenland, M.D., Northwestern University, 312-908-7914

James Neaton, Ph.D., University of Minnesota, Division of Biostatistics, 612-626-9040

Mary Cushman, M.D., M.S.C., University of Vermont, College of Medicine, 802-656-8959

Eric Boerwinkle, Ph.D., University of Texas, Health Sciences Center at Houston, 713-500-9816

Charles Rotimi, Ph.D., Howard University, Director for Genetic Epidemiology, 202-806-5419

Alexander Wilson, Ph.D., National Institutes of Health, NHGRI, 410-550-7510

A.9. Explanation of Any Payment or Gift to Respondents

There is no payment or gift to respondents in return for their participation.

A.10. Assurance of Confidentiality Provided to Respondents

A.10.1 Human Subjects

Participation in this study is voluntary. The contract stipulates that research involving human subjects is subject to an annual review to be submitted each year. A copy of the letter from the Boston University Institutional Review Board Coordinator indicating approval of the study is attached. The consent forms describe the study to participants, inform them of the risks and benefits of procedures, and indicate where to obtain information about the rights of research subjects.

A.10.2 Privacy Act

The information obtained by The Framingham Study will be included in the Privacy Act system of records 09-25-0126, Clinical Research: National Heart, Lung, and Blood Institute Epidemiological and Biometric Studies, HHS/NIH/NHLBI.

Individuals will be informed that they may refuse to participate in the examination and that their refusal will not result in any loss of benefits to which they might otherwise be entitled, nor will it adversely affect any medical care. Consent forms are attached.

Except as permitted by the Privacy Act, or in accordance with routine uses established for this system, the data from this study may be used only to evaluate epidemiological determinants of health, cardiovascular disease, and risk factors and mortality by cause of death.

A.10.3 Clinic and Data Security

Access to the data will be restricted to protect the rights of individuals involved. Data will be given only to NHLBI employees and contract personnel associated with the project on an as needed basis, unless otherwise provided by law. The information obtained by The Framingham Heart Study will be established and maintained in computer data files and also stored in paper record files. Each participant will be provided with written assurance on their consent forms that all individual data collected in the study will be kept confidential to the extent provided by the Privacy Act and in accordance with routine use established for this system.

All records, including individually identifiable records, will be kept in locked files. Access to files

which link identification numbers with names will be restricted and made available only to authorized project personnel. Access to the data will be controlled by the Principal Investigator and the Project Officer. Data stored in computers will be accessed through the use of key words known only to principal investigators or authorized project personnel. Additionally, all contract personnel, including physicians, are made aware of and bound by the Privacy Act clause in the contract.

A.11. Justification for Sensitive Questions

During the Original Cohort Examinations Number 30 and 31 and the Generation Three Cohort Examination Number 2, the Framingham Study is collecting information which is sensitive, as listed below. The steps which are being taken to safeguard the documents and files containing potentially sensitive information are the same as those described in Section A.10. Respondents are being fully informed in writing about the nature of the study, the voluntary aspects of their participation, benefits from participation, risks associated with participation, and the extent to which confidentiality of identifiable information can be assured.

Informed consent is obtained from all participants; the forms are attached. The participants are fully informed of the content and procedures in the examination. They are informed that they can refuse any or all of the examination without any penalties. The reasons for the collection of the information and the study=s use of the information are described below and are verbally given to the participant if he/she has any questions.

Social Security Number was provided by participants at earlier examinations and it will be asked again. Social security number was requested to facilitate tracking of events, especially deaths with the National Death Index.

Alcohol consumption will be determined in the Generation Three Cohort study since studies have suggested that moderate levels of alcohol use may be protective for coronary heart disease. Because alcohol consumption may change over time, particularly with the onset of illness, this information collection is a repeat of that from earlier examinations.

The Center for Epidemiologic Studies Depression (CES-D) Scale is a depression scale administered to the Original Cohort and Generation Three Cohort. Data from this instrument will be collected to investigate the relationship between depressive symptomatology and clinical cardiovascular events. Data on depression will also be used to assess the impact of clinical events and to determine short- and long-term disability following events.

Berkman Social Network Questionnaire is a social engagement questionnaire administered to the Original and Generation Three Cohorts to assess social connections and activities. The 13 questions will include information about closeness to friends and relatives, participation in religious and social activities, and frequency of contact with other individuals. This domain is being studied because lack of social engagement has been shown to be a risk factor for cognitive decline.

Cognitive function questionnaires being used in both the Original and Generation Three Cohorts to request information to assess the participants= memory and mental capacity. These data are essential in characterizing the severity and sequelae of stroke. These data are also necessary for research into causes of dementia (Alzheimer=s disease).

Continence is being assessed the Original Cohort. Both bladder and bowel continence are items in the Activities of Daily Living Scale; the participant is asked if he or she has Aaccidents.@ These items are part of a standardized questionnaire that assesses activities of daily life and degree of independence and autonomy; they are essential to determine

predictors of disability and nursing home admission in the elderly.

Current medication use is being determined in both the Original Cohort and Generation Three Cohort, as many blood chemistry values are modified by pharmacologically active drugs. Thus knowledge of the use of prescription as well as over-the-counter medications is required to interpret the blood chemistry values. In addition, several medications are modifiers of onset and progression of clinical events (e.g., aspirin, beta blockers), and will be used as covariates in analyses. Information on use of anti-hypertensive and diabetic medications are necessary to assess whether a participant has either of these conditions.

Age at tubal ligation and oral contraceptive use are being assessed in the Generation Three Cohort female genitourinary disease form. Oral contraceptives contain estrogen and/or progestin which have effects on lipid levels, glucose metabolism, and coronary disease risk. Tubal ligation has also been potentially linked to changes in estrogen status.

Informant interviews for cardiovascular disease deaths are being conducted with informants previously designated by the participant to determine the circumstances surrounding a participant=s death. The information from these interviews is critical in determining whether or not a death was due to cardiovascular causes, which is the primary endpoint of the study. While these interviews conceivably have the potential for exacerbating grief or producing anxiety or guilt in the respondents, they have been well accepted to date in The Framingham Study and other studies as well, such as The Cardiovascular Health Study (OMB 0925-0334). Staff are experienced in allowing the informants to discuss their feelings openly and at length as needed. They also emphasize the value of this information to the research goals of The Framingham Study, in which the decedent was an important member, in the hope that some comfort may be derived from this knowledge.

A.12. Estimates of Hour Burden Including Annualized Hourly Costs

The estimate for respondent burden for the Original Cohort is presented in Table A.12–1.1, for the Generation Three Cohort in Table A.12-1.2, and for the Offspring Cohort in Table 12-1.3 below. These tables cover the three-year period from 1/1/2008 to 12/31/2010, with all values annualized. Combined annualized totals are shown in Table 12-1.4.

Table A.12-1.1
ESTIMATE OF RESPONDENT BURDEN, ORIGINAL COHORT
1/1/2008-12/31/2010, ANNUALIZED

Participant components	Number of Respondents	Frequency of Response	Average Time per Response	Annual Hour Burden
a. Telephone contact to set up appt	300	1	0.17	51
b. Appt. Confirmation	200*	1	0.17	34
c. Clinic information	100*	1	0.72	72
d. Clinic exam	100*	1	0.78	78
e. Home or nursing home visit	100*	1	1.20	120
f. Follow-up contact	300*	1	0.03	9
g. Health status update (every 2 yrs)	100*	1	0.13	13
TOTAL, PARTICIPANT COMPONENTS, CYCLE 30-31	300			377
Non-participant components				
a. Physician, hospital and nursing home contacts	250	1	0.67	168
b. Informant contact	250	1	0.08	20
TOTAL, PARTICIPANT AND NON-PARTICIPANT COMPONENTS	800			565

*Participants included in Item a.

Table A.12-1.2
ESTIMATE OF RESPONDENT BURDEN, GENERATION THREE COHORT
1/1/2008-12/31/2010, ANNUALIZED

Participant components	Number of Respondents	Frequency of Response	Average Time per Response	Annual Hour Burden
a. Telephone contact to set up appt	1169	1	0.17	199
b. Appt. Confirmation	1000*	1	0.17	170
c. Clinic information and exam	1000*	1	3.5	3500
d. Health status update & next generations update (every 2 yrs.)	1000*	1	0.17	170
TOTAL, PARTICIPANT COMPONENTS, EXAM 9	1169	1		4039
Non-participant components				
a. Physician, hospital and nursing home contacts	300	1	0.67	201
b. Informant contact	300	1	0.08	24
TOTAL, PARTICIPANT AND NON-PARTICIPANT COMPONENTS	1769			4264

*Participants included in Item a.

Table A.12-1.3
ESTIMATE OF RESPONDENT BURDEN, OFFSPRING COHORT
1/1/2008-12/31/2010, ANNUALIZED

Participant components	Number of Respondents	Frequency of Response	Average Time per Response	Annual Hour Burden
Health status update (2000/yrX 3 yrs)	2000	1	0.17	340
CT exam	400	1	1	400
TOTAL PARTICIPANT COMPONENTS	2400			740
Non-participant components				
a. Physician, hospital and nursing home contacts	300	1	0.67	201
b. Informant contacts	300	1	0.08	24

TOTAL, PARTICIPANT AND NON-PARTICIPANT COMPONENTS	3000	965

Estimates of annualized total hour burden are summarized in Table A.12 – 1.4 below.

Type of Respondents	Number of Respondents	Frequency of Response	Average Time per Response	Annual Hour Burden
Individuals (Participants and Informants)	4719	1	1.107	5224
Physicians	850	1	0.671	570
Totals	5569	1		5794

(Note: reported and calculated numbers differ slightly due to rounding.)

The annualized cost to the participants consists of the cost of their time for which no remuneration is given, and transportation costs. Assuming $18.65 per burden hour for participants and informants and $75 per burden hour for physicians and other professional health care respondents, the annual cost for time is $140,177.60. The average travel distance for participants coming to the Framingham clinic is 10 miles round trip; the cost per mile is estimated at $0.48. Participants needing transportation (15% of the original cohort and 2% of the offspring cohort) are provided with taxis; the taxi service is paid directly by the study. The total annual cost for transportation is $1429. Respondent cost burden is summarized in Table A.12-2 below.

A.12 - 2 ANNUALIZED COST TO RESPONDENTS			
Type of Respondents	**Number of Respondents**	**Hourly Wage Rate**	**Respondent Cost**
Individuals	5679	$18.65	$97,427.60
Physicians	850	$75.00	$42,750.00
			Total: 140,177.60

(Note: reported and calculated numbers differ slightly due to rounding.)

A.13. Estimate of Other Total Annual Cost Burden to Respondents or Recordkeepers

There are no other total annual costs which apply to respondents or recordkeepers in The Framingham Study. There are no Capital Costs, Operating Costs, or Maintenance Cost to report.

A.14. Annualized Cost to the Federal Government

The Framingham Study is largely being run by a contractor. At the same time, there are NHLBI staff on the site contributing to the conduct of the study and NHLBI contributes directly to some of the costs of the study. Table A14 -1 presents total costs for 1/1/08-12/31/10 and average annual costs, broken down by whether the costs are part of the contract or not.

TABLE A.14-1 COSTS TO THE GOVERNMENT FOR INFORMATION COLLECTION, THOUSANDS OF DOLLARS				
Type of Cost	**Contract**	**Other**	**Total**	**Total Average Annual Costs**
Study Management and Operation	$7176	$731	$7907	$7905
Monitoring		$128	$128	$128
Total	$7176	$859	$8035	$8035

A.15. Explanation for Program Changes or Adjustments

The annual hours requested is reduced slightly from the current OMB inventory. The reduction is due to a smaller number of participants being examined than was previously estimated.

A.16. Plans for Tabulation and Publication and Project Time Schedule

Framingham will analyze the collected information in a timely manner after the necessary data editing has been done. The timetable for data collection and analysis, in terms of the time elapsed following OMB approval, is presented in Table A.16 - 1.

Table A.16 - 1 Time schedule for three-year Framingham Study continuation

Activity	**Time elapsed after OMB approval**
Participant contact and appointment scheduling	1 to 36 months
Data collection	1 to 36 months
Analysis	12 months to 5 years
Publication	24 months to 5+ years

To achieve the ultimate goal of determining policy recommendations for cardiovascular disease prevention, the intermediate goal of analyzing data and presenting results needs to be met. Numerous examples of the statistical analyses used by the Framingham investigators are available in the published literature; publications are attached. Data to be collected will be merged with that from previous examinations and analyzed in a longitudinal fashion to gain better understanding of the dynamic features of cardiovascular disease. At the same time, cross-sectional analysis of the newly collected data will also occur. Results of both types of analyses will be presented to the public by publishing in scientific journals such as New England Journal of Medicine, Journal of the American Medical Association, Circulation, and Annals of Internal Medicine; by oral and poster presentation at scientific meetings (e.g. American Heart

Association, Council on Cardiovascular Epidemiology, American College of Cardiology); and by publishing book chapters.

The extent and complexity of The Framingham Study necessitates that future statistical analyses will cover many topics and will be ongoing. Examples of analytic topics which will be expanded upon using future Framingham data can be found in the titles of some of the recent publications. A list of some other topics to be addressed in possible future publications follows:

Trends in the prevalence of stroke

Trends in hypertension treatment and impact on prevalence of high blood pressure and left ventricular hypertrophy

Serum biomarkers as predictors of premature coronary heart disease

Effects of gender, age, and menopausal status, and genome on plasma lipoprotein subspecies

Distribution and amount of adipose tissue as risk factor for cardiovascular disease

Heritability of dyslipidemia and diabetes

Impact of different anthropometric and apolipoproteins E isoforms on lipids and blood pressure

Association of apolipoprotein E genotype with doppler indexes of left ventricular filling

Attribution of dyslipidemia to overweight

Interaction of physical activity and overweight on risk of cardiovascular disease

Dietary fiber and subsequent coronary heart disease

Dietary flavonoids and subsequent cardiovascular disease

Coronary disease risk factor clusters: progression and impact on coronary heart disease

Prediction of carotid stenosis

Predictors of mortality following the onset of atrial fibrillation

Antecedent hypertension confers increased risk for adverse outcomes following initial

myocardial infarction

Risk factors for syncope

Long term influence of fibrinogen on cardiovascular events

Blood pressure as a hazard in the very old

Vitamin C intake, folate status, and plasma homocysteine

Folate intake pattern as a determinant of plasma folate and homocysteine levels

Prognostic importance of heart rates during recovery after exercise

Heritability of left ventricular mass

Assessment of pre and post myocardial infarction angina

Prevalence and clinical correlates of diastolic heart failure

Prognosis of diastolic heart failure

Outcomes after syncope

Genome-wide association studies of predictors of cardiovascular disease

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB Expiration Date will be displayed as required.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to Certification for Paperwork Reduction Act Submissions.