Five years ago, the American Heart Association (AHA) launched a bold new initiative to begin promoting “cardiovascular health” in individuals and the population, in addition to continuing its decades-long fight to reduce cardiovascular and stroke mortality and decrease cardiovascular disease (CVD) risk. This shift in priorities came as a result of a “quiet revolution,” turning the adverse-outcomes-oriented and risk-focused perspective on its head, and instead focusing on creating the opportunity for promoting and preserving attributes associated with healthy, CVD-free longevity. The first-ever formal definition for this construct of cardiovascular health, published in 2010,2 was based on a broad review of the literature designed to determine groups of factors associated with excellent prognosis in long-term CVD-free survival and quality of life. It was designed to be simple, accessible, and actionable, allowing all patients, clinicians, and communities to focus on improving cardiovascular health. And it was crafted in a way so that it could be measured in the broad US populations from around the globe.3–8 In countries with more prevalence of levels of ideal cardiovascular health in diverse populations,8–12 one examines data on this ideal cardiovascular health concept is that the whole may indeed be greater than the sum of the parts. The Framingham investigators provide the latest pieces of evidence linking greater cardiovascular health to favorable outcomes with regard to CVD incidence. The major contribution these authors make is in filling some of the gaps in our understanding about the mechanisms underlying the association of greater cardiovascular health with lower disease incidence. One may legitimately ask: Do people with better cardiovascular health simply develop less subclinical disease (atherosclerosis or vascular or myocardial damage) over time and therefore they are at lower CVD risk just because of that? Or is there possibly more to it? Xanthakis et al characterized 2680 mostly middle-aged Framingham Study participants with regard to their cardiovascular health status on all 7 metrics at baseline. Consistent with the approach taken by many other investigators, they created a simple score from 0 to 7 points indicating how many cardiovascular health metrics each participant had at ideal levels. They then examined associations of the score with various serological markers of inflammation, coagulation, and target-organ damage, as well as measures of subclinical CVD, including...
What are we to make of this? To be sure, we must be cautious and recognize the potential for residual confounding. The vast majority of CVD events are of course preceded by evidence of vascular or myocardial alterations or damage, and the measures available to the authors for this analysis incompletely represent all of the causal pathways involved in the transition from cardiovascular health to CVD. Nonetheless, the Framingham investigators have provided the most interesting data to date examining potential mechanisms underlying the construct of cardiovascular health. Their data suggest that there might be additional intangible benefits of the cardiovascular health phenotype, perhaps related to other aspects of a healthy lifestyle, or the tendency for longer exposure to favorable levels of cardiovascular health metrics among those with greater cardiovascular health (because it is easier and more common to preserve it than restore it).

Such speculations require further investigation. In the meantime, these data provide even more strong and compelling evidence that, regardless of the mechanism, promotion of cardiovascular health must be advanced immediately and forcefully as a key part of the national agenda at every level of policymaking, across all healthcare and public health systems, and for all segments of the population. Only with maximal effort can we blunt the substantial burden of CVD and CVD-related costs that are impending over the next decades. To promote and achieve a culture of health in which all Americans, and particularly our youth, can achieve healthy longevity, where cardiovascular health is poor, we must improve it; where it is intermediate, we must restore it; and where ideal, we must preserve it.

### Disclosures

None.

### References


**Key Words:** Editorials, cardiovascular outcomes, health status, risk factor