



**Federal Interagency Health Equity  
Team**

**Compendium of Publicly Available  
Datasets And Other Data-Related  
Resources**

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# Introduction

Health and health care disparities in the United States adversely affect groups of people who have systematically experienced greater obstacles to health and health care based on their racial and/or ethnic group; religion; socioeconomic status; gender; sexual orientation or identity; age; mental health; cognitive, sensory or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion. Health and health care disparities are persistent and pervasive, negatively affecting not only the individual but also the nation as a whole.

Achieving health equity requires valuing everyone equally with focused and continuing societal efforts to address preventable inequities, historical and contemporary injustices, and the elimination of health and health care disparities. According to the World Health Organization (WHO), reducing inequities in health is important because health is a fundamental human right, and its progressive realization will eliminate inequalities that result from differences in health status (such as disease or disability).

In the United States, numerous efforts are ongoing to reduce or eliminate inequities. These efforts emphasize risk factors that considerably impact health. These factors – known as social determinants of health – include socioeconomic status, quality education, safe and healthy housing, access to affordable healthy and fresh foods, and access to and use of quality health care. Inequities in these determinants of health contribute to poor health outcomes and health disparities.

Launched in 2011, the National Partnership for Action to End Health Disparities (NPA) is a national movement designed to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action, and by bringing attention to the social determinants of health. The NPA set forth the following five essential goals necessary for the elimination of health and health care disparities:

<b>Goal 1: Awareness</b>	<b>Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial and ethnic minorities and underserved populations.</b>
<b>Goal 2: Leadership</b>	<b>Strengthen and broaden leadership for addressing health disparities at all levels.</b>
<b>Goal 3: Health System and Life Experience</b>	<b>Improve health and health care outcomes for racial and ethnic minorities and underserved populations.</b>
<b>Goal 4: Cultural and Linguistic Competency</b>	<b>Improve cultural and linguistic competency and the diversity of the health-related workforce.</b>
<b>Goal 5: Data, Research and Evaluation</b>	<b>Improve data availability and coordination, utilization and diffusion of research and evaluation outcomes.</b>

To achieve these goals, the NPA involves partners from the federal, national, regional, local, state, tribal and territorial, and local levels. Federal agencies, such as the U.S. Departments of Agriculture, Commerce, Defense, Education, Health and Human Services, Labor, Justice, Transportation, Housing and Urban Development, and Veterans Affairs; the Consumer Product Safety Commission; and the Environmental Protection Agency, came together under the leadership of the U.S. Department of Health and Human Services Office of Minority Health to form the Federal Interagency Health Equity Team (FIHET). The purpose of the FIHET is to identify opportunities for federal collaboration, partnership, coordination and/or action on efforts relevant to the NPA; provide leadership and guidance for federal, regional, state, tribal, territorial, and local efforts to address health equity; and infuse health disparities and health equity goals and strategies into member agency policies and practices. The FIHET is divided into several workgroups that deal with the NPA priorities, one of these being the FIHET Data, Research and Evaluation Workgroup. The FIHET Data, Research and Evaluation Workgroup's first task was to develop a resource of publicly available data relevant to research and programs aiming to reduce health disparities – the Compendium of Publicly Available Datasets and other data-related resources (“Compendium”). This task and the resulting resource reflect the participating federal agencies' efforts to identify opportunities within each of their agencies to promote equity in the social determinants of health by making data available and accessible to the public and to researchers working in the field.

## **Process for Developing the Compendium**

To initiate the process of developing the Compendium, a data call was issued from the FIHET Data, Research and Evaluation Workgroup to all FIHET members for information on datasets available from their agencies. A template with specific fields was created by the workgroup to facilitate collection and to ensure that the information extracted from existing datasets was consistent. The template's specific fields included the name of each dataset or related resource; the source for the information (e.g., URL link); a brief description of the dataset or resource; the target population, disaggregated by age, race and ethnicity, and socioeconomic variables; the smallest geographic unit for which the data are available (e.g., state, county); the years for which the data are available; and the existence of periodic reports originated from a dataset. Information about whether data are available for U.S. territories and tribes is included in the brief description of the specific dataset. Each agency representative completed and returned the template for an initial review by the FIHET Data, Research and Evaluation Workgroup's chair and members. A second round of review was conducted by the workgroup for relevance and completeness of the information. Finally, data experts from each agency for which information on the datasets was collected were asked to review the content of the templates to ensure accuracy of the information pertinent to datasets from their agencies and to obtain concurrence on the content of the compendium. At each step of the review process, comments received were reviewed and incorporated as needed prior to finalization of the Compendium.

## **Use of the Compendium**

This Compendium is a resource, but it is not an exhaustive compilation of all existing datasets. It includes datasets and data-related resources from the following federal agencies within the U.S. Department of Health and Human Services: Administration for Community Living (ACL); Agency for Healthcare Research and Quality (AHRQ); Centers for Disease Control and Prevention (CDC); Centers for Medicare & Medicaid Services (CMS); Health Resources and Services Administration (HRSA); Indian Health Service (IHS),

National Institutes of Health (NIH); and Substance Abuse and Mental Health Services Administration (SAMHSA). It also includes information on datasets from the U.S. Census Bureau at the U.S. Department of Commerce. The Compendium is a work in progress that will continue to incorporate datasets and resources from agencies within HHS and from other potentially interested federal partners, including the U.S. Environmental Protection Agency and U.S. Departments of Transportation, Labor, Education and Veterans Affairs.

The following information is provided for each dataset or data-related resource:

- **Data Source** – Name of the dataset and link to website (if available);
- **Brief Description** – General information about the dataset;
- **Examination Components** – Brief information on the dataset components, which may include data collection procedures and data use;
- **Target Population** – The target population or group targeted for data collection (e.g., infants, children, adolescents, adults, older adults, individuals with disabilities);
- **Age** – Information about the ages or age groups of the target population included in the dataset;
- **Race & Ethnicity** – Race and ethnicity (e.g., Black or African American, Hispanic or Latino) information about the population included in the dataset; the Office of Management and Budget (OMB) categories for race and ethnicity include white, black or African-American, Asian, Native Hawaiian and other Pacific islanders, American Indian or Alaska Native. Hispanic origin is asked as a separate question.
- **Socio-Economic Variables** – Socio-economic variables (e.g., income, education, employment) about the target population included in the dataset;
- **Geographic Estimates** – Lowest or smallest geographic unit (e.g., state, county, ZIP code, census tract) for which the data are available;
- **Years of Data Collected** – Years for which data collected are available;
- **Public Availability** – Indicates whether or not data are available for public use; and
- **Periodic Reports** – Indicates whether or not reports are available and how frequently reports are generated from the data.

An indication of “– “ in any of the columns means that the information is not readily available or that the datasets do not have the information.

The Compendium is available to all interested parties, from researchers to laypersons, with information on populations affected by specific health outcomes. Depending on the user’s goals and objectives, these datasets can serve a variety of purposes – from research, policy and program development to general public knowledge. For example, researchers interested in studying the specific health services that Americans frequently use, the cost of such services and their payment methods can access the Medical Expenditure Panel Survey (MEPS) data source available from AHRQ. Organizations with the mission to promote youth education on the use of illegal drugs, alcohol and tobacco, and on the problems associated with such use can access the National Survey on Drug Use and Health (NSDUH) from SAMHSA. Organizations interested in program and policy development for children and families served by Head Start and Early Head Start programs can access the Head Start Program Information Report (HSPiR) from ACF. These are a few examples of how publicly available data sources included in

the Compendium can be utilized by individuals and organizations that are interested in reducing health disparities and advancing equity for all.



## Department of Health and Human Services Administration for Community Living



**Data Source:** Access to Integrated Employment: National Data Collection on Day and Employment Services for Citizens with Developmental Disabilities ([www.statedata.info](http://www.statedata.info))

**Brief Description:** The Access to Integrated Employment: National Data Collection on Day and Employment Services for Citizens with Developmental Disabilities project is a longitudinal study describing day and employment services nationwide for individuals with developmental disabilities. The project studies the effectiveness of state developmental disabilities agencies and vocational rehabilitation agencies in promoting full inclusion of individuals with intellectual and developmental disabilities through employment and other community activities; describes national trends in the employment and economic status of youth and adults with intellectual and developmental disabilities on a state and national basis; highlights practices and outcomes in the transition from school to employment, and promotes policy-enhancing, integrated employment at both the systems and customer levels; develops guidelines for community-based nonwork activities; provides an online catalog of innovative state-level strategies that influence policy and facilitate access to integrated employment; collaborates with the University of Minnesota and the University of Colorado to show targeted current year and longitudinal data on the project website. Contact Organization is the Administration for Intellectual and Developmental Disabilities (AIDD) within the Administration for Community Living (ACL).

**Examination Components:** Sources include the Institute for Community Inclusion's Individuals with Developmental Disabilities Agency National Survey of Day and Employment Services (from FY1999, 2001, 2004, 2007, 2008, 2009, 2010, 2011, 2012 and 2014) and datasets from the Social Security Administration, Rehabilitation Services Administration, Bureau of Labor Statistics, and the American Consumer Survey.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	White alone, Not Hispanic; White alone, Hispanic; Native American alone; Asian alone; Black/African American alone; Hawaiian Pacific Islander alone; Other Race; Two or More Races	No	National, State	Since mid 1980s	Yes, data reports will be available on the ACL website (in development)	Yes, online availability: <a href="http://www.statedata.info/about/data-sources">http://www.statedata.info/about/data-sources</a>

**Data Source: Aging Integrated Databases (<http://www.agid.acl.gov/>)**

**Brief Description:** Aging Integrated Databases (AGID) is an online query system based on Administration on Aging (AoA)-related data files and surveys that includes population characteristics from the U.S. Census Bureau for comparison purposes. The four options or paths through AGID provide different levels of focus and aggregation of the data; these four paths include Data-at-a-Glance, State Profiles, Custom Tables and Data Files. In addition, links to reports are provided (e.g., State Program Reports, National Ombudsman Reporting Systems, Title VI Services by Tribal Organization, National Survey of Older Americans Act participants).

**Examination Components:** Administration on Aging (AoA)-related files include State Program Reports, National Ombudsman Reporting Systems, Title VI Services by Tribal Organization, National Survey of Older Americans Act participants, National Survey of Area Agencies on Aging. Census Bureau files include state-level population estimates data as well as county and primary statistical area-level population estimates data.

Decennial Census 2010 Summary File 1 (SF1) data; American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year files; AoA Special Tabulation: American Community Survey 2007-2011; AoA Special Tabulation: American Community Survey 2009-2011, Disability Tables; AoA Special Tabulation: Decennial Census 2010; AoA Special Tabulation: American Community Survey 2005-2009; AoA Special Tabulation: American Community Survey 2008-2010, Disability Tables.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults across race and ethnicity	Adults (25-64 years) and older adults (65+)	All races & ethnicities – depending on the database	Education level	National, State	Varies depending on data set	Yes, online query. Data-at-a-glance: a) AoA databases – State Program Reports 2005-2012; National Ombudsman Reporting Systems 2000-2012; Title VI Services by Tribal Organization 2002-2012. b) Census Databases – American Community Survey demographic data (2004-2012; population estimates data 2000-2012); Census 2010	Yes, online availability

**Data Source: Data Collection for Supporting Families – Annual Monograph**

([http://www.acl.gov/Programs/AIDD/Programs/PNS/Resources/DataCollection\\_SupportingFamilies.aspx](http://www.acl.gov/Programs/AIDD/Programs/PNS/Resources/DataCollection_SupportingFamilies.aspx))

**Brief Description:** Collaborating with the National Association of State Directors of Developmental Disabilities Services, HRSA, the Association of University Centers on Disabilities, the National Down Syndrome Society, the National Youth Leadership Network, Parent Information Centers, Parent to Parent USA and other organizations providing family support, the Data Collection for Supporting Families Project examines data from the services and supports provided to families who have a family member living in the home. Guided by a family expert panel, the project accesses data on state supports and services that have been previously collected; develops key definitions related to supports and services; generates a standard set of key state indicators that can be used to benchmark progress; creates a profile of such supports and services that can be updated and used to track trends; implements an annual data collection effort that produces reliable national and state-by-state data about family supports using strategies designed to ensure that the information reported by states is accurate and comparable across states; produces an interactive website with an online data dashboard that can be used to track, compare and contrast progress made on achieving outcomes at the national and state levels; and designs a plan to develop an electronic, web-based data distribution system that will be easily accessible to families and people with intellectual or developmental disabilities. Contact Organization is the Administration for Intellectual and Developmental Disabilities (AIDD) within the Administration for Community Living (ACL).

**Examination Components:** This report describes the results of two surveys for Fiscal Year 2012, which ran from July 1, 2011, through June 30, 2012.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	All races & ethnicities	No	National, State	Since 2011	Yes, data reports will be available on the ACL website (in development)	Yes, online availability

**Data Source:** National Data Measurement Project: National Core Indicators – Annual Report ([www.nationalcoreindicators.org](http://www.nationalcoreindicators.org))

**Brief Description:** The National Core Indicators project gathers data on over 100 key outcome indicators that are designed to gather valid and reliable data across five broad domains: individual outcomes; family outcomes; health, welfare and rights; staff stability; and system performance. Contact Organization is AIDD within the ACL.

**Examination Components:** The National Core Indicators database includes randomly selected representative samples by state, with 39 states contributing data.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	American Indian or Alaska Native; Asian; Black/African American; Pacific Islander; White; Other; Two or More Races	No	National, state	Since 1997	Yes, data reports will be available on the ACL website (in development)	Yes, online availability

**Data Source: The National Residential Information System Project – Biennial Monograph (<http://www.rtc.umn.edu/risp>)**

**Brief Description:** The National Residential Information System Project (RISP) is a longitudinal study of annual state-by-state and national statistics on residential services and supports for people with intellectual and developmental disabilities. The project gathers and maintains annual statistics and longitudinal trend data on Medicaid and state-funded residential and in-home supports for people with disabilities. The project utilizes a large multistate database on individuals with developmental disabilities to examine the associations between personal characteristics, housing, financing and support models, state systems on inclusion, self-determination, satisfaction and outcomes; conducts state policy and program surveys on key topics in residential and other community services; and maintains a clearinghouse of information and resources on consumer-controlled housing, the direct support workforce and community living outcomes. Contact Organization is AIDD within ACL.

**Examination Components:** This report is based on data from an annual survey of state I/DD agencies covering aggregated state statistics and an annual survey of administrators describing the characteristics of large (16 or more residents) state I/DD facilities. Secondary data sources are used to add data elements not collected as part of the RISP project (such as state population and the federal Medicaid cost match rate) and to supplement data provided by states with data from other reports such as the State of the States report (Braddock et al., 2013) and the Centers for Medicare & Medicaid Services (CMS) Online Survey Certification and Review (American Health Care Association, 2011).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	All races & ethnicities	N/A	National, State	Since 1977	Yes, data reports will be available on the ACL website (in development)	Yes, online availability

**Data Source:** Protection and Advocacy Systems Program Performance Reports (<http://www.acl.gov>)

**Brief Description:** Protection and Advocacy Systems (P&As) work at the state level to protect individuals with developmental disabilities by empowering them and advocating on their behalf. There are 57 P&As in the United States and its territories. P&As provide legal support to traditionally unserved or underserved populations to help them navigate the legal system to achieve resolution and encourage systems change. P&As ensure that individuals with disabilities are able to exercise their rights to make choices, contribute to society and live independently. P&As also provide information and referrals as well as training and technical assistance to service providers, state legislators and other policymakers. They also conduct self-advocacy trainings. P&As provide legal advocacy in various areas, including health. Contact Organization is AIDD within ACL.

**Examination Components:** P&As submit program performance reports via the Protection and Advocacy for Developmental Disabilities Program Performance Report (PADD PPR) system. They report on legal advocacy activities in multiple areas, including health.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	Asian; Black or African American; Hispanic/Latino; American Indian or Alaska Natives; Native Hawaiian and Other Pacific Islanders; White; Multiple Responses; No Information Provided	Living conditions: independent; parental or family home; foster care; nursing home; public state-operated; private institutes; legal detention jail/prison; homeless; federal facility; other.	National, State	Since 2003	Yes, data reports will be available on the ACL website (in development)	Yes, online availability

**Data Source:** The State of the States in Developmental Disabilities – Biennial Monograph (<http://stateofthestates.org/>)

**Brief Description:** The State of the States in Developmental Disabilities is a comparative nationwide longitudinal study of public financial commitments and programmatic trends in developmental disabilities services and supports. The project’s activities include analyzing developmental disabilities financial and programmatic trends in each state and the District of Columbia; identifying trends and innovations in the financing of family-supported living and supported employment in the states; completing special studies such as Medicaid spending for special education; collaborating with the University of Massachusetts and the University of Minnesota to show targeted current year and longitudinal data on the project website, and providing a create-a-chart option that allows reports to be customized. Contact Organization is AIDD within ACL.

**Examination Components:** Data collection procedures included: 1) acquisition and analysis of budget and program documents from each state and the District of Columbia; 2) development of 51 specialized state survey instruments reflecting the fiscal and programmatic characteristics of each state and the District of Columbia; 3) implementation of these surveys in all states and the District of Columbia; and 4) extensive collaboration with state agency officials to obtain, verify and interpret the intellectual/developmental disabilities (I/DD) financial and programmatic data collected.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64; and older adults (65+)	All races & ethnicities	No	National, State	Since 1983	Yes, data reports will be available on the ACL website (in development)	Yes, online availability

**Data Source: University Centers for Excellence in Developmental Disabilities Program Performance Reports**  
<http://www.acl.gov/programs/aidd/Programs/UCEDD/index.aspx>

**Brief Description:** University Centers for Excellence in Developmental Disabilities (UCEDD) are a nationwide network of interdisciplinary centers that conduct interdisciplinary pre-service preparation and continuing education, research, information dissemination and community services, including direct services, training, technical assistance and model demonstrations that address the needs of individuals with developmental disabilities and their families, most particularly those who are unserved or underserved. UCEDDs support activities that address various issues, from prevention to early intervention to health. There are 68 UCEDDs in the states and territories. Contact Organization is AIDD within the ACL.

**Examination Components:** UCEDDs use the National Information Reporting System (NIRS) to report on the number of specialized services offered by the UCEDD to enhance the well-being and status of the recipient and the number of individuals who received specialized services from the UCEDD to enhance the well-being and status of the recipient.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with developmental disabilities	Infants/toddlers; children; youth (early teens-18); young adults (18-24); adults (25-64); and older adults (65+)	White; Black or African American; Asian; Native Hawaiian and Other Pacific Islanders; American Indian or Alaska Native; Hispanic origin is asked as a separate question	No	National, State	Since 2003	Yes, data reports will be available on the ACL website (in development)	Yes, online availability



## Department of Health and Human Services Agency for Healthcare Research and Quality



**Data Source:** Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey (<http://cahps.ahrq.gov>)

**Brief Description:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey collects information on enrollees' experiences with health plans and their services. The database contains commercial and Medicaid survey results submitted by various sponsors, including public and private employers, state Medicaid agencies, state Children's Health Insurance Programs and individual health plans since 1998.

**Examination Components:** Measures patient experience: getting needed care; getting care quickly; how well doctors communicate; health plan information; and customer service. There are four global ratings in which patients rate their health plans, health care, personal doctors and specialists.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults and children. Commercial, Medicare, and Medicaid populations.	Adults and Children ages 18 and younger	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Education <sup>1</sup>	City	2000-2011	Research files available upon request	Results are reported in the fall of each year from 2000-2011; data intake and reporting will resume July 2013

<sup>1</sup> Other variables: Self-reported health status

**Data Source:** Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (<http://cahps.ahrq.gov>)

**Brief Description:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey asks patients about their recent experiences with clinicians and their staff. The Clinician and Group Database contains survey data submitted by practice sites and practice groups on patient experiences with doctors and medical groups by region, physician specialty, practice ownership and affiliation, number of visits by practice and survey mode.

**Examination Components:** Getting timely appointments, care and information; how well providers (or doctors) communicate with patients; helpful, courteous, and respectful office staff; patients’ rating of the provider (or doctor).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults and children ages 18 and younger. Clinician practice and medical groups	18 to 75+	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Education <sup>2</sup>	Region	2010-2013	Research files available upon request	Results are reported annually

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<sup>2</sup>Other variables: Health status

**Data Source: Healthcare Cost and Utilization Project (<http://www.hcup-us.ahrq.gov>)**

**Brief Description:** Healthcare Cost and Utilization Project (HCUP) has six data resources: Nationwide Inpatient Sample; Kids Inpatient Database; Nationwide Emergency Department Sample; State Inpatient Database; State Emergency Department Database; and State Ambulatory Surgery Database. HCUP is a family of health care databases and related software tools and products developed through a federal-state-industry partnership. HCUP databases bring together the data collection efforts of state data organizations, hospital associations, private data organizations and the federal government to create a national information resource of patient-level health care data (HCUP Partners). HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services; medical practice patterns; access to health care programs; and outcomes of treatments at the national, state and local market levels. HCUPnet is a free, online query system that provides access to health statistics and information on hospital inpatient and emergency department utilization.

**Examination Components:** Surveys, databases, discharges from acute care community hospitals from 47 states. Data are from billing data collected through a public or private data entity within each state. Databases include discharges from all hospitals in each of the states. HCUP standardizes the databases so that the data elements are standard across the various databases. Discharges from all acute care hospitals; data are collected yearly beginning in 1988. HCUP has the following components: HCUP NIS (National Inpatient Sample); HCUP KID (KID's Inpatient Database); HCUP NEDS (Nationwide Emergency Department Sample); HCUP SID (State Inpatient Database); HCUP SASD (State Ambulatory Surgery Database), and HCUP SEDD (State Emergency Department Database).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults and children ages 21 and younger	Adults and children ages 21 and younger	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Over 100 clinical and nonclinical variables in a hospital discharge abstract. For some states, patient demographics information includes race; expected payment source (e.g., Medicare, Medicaid, private insurance, self-pay, and for some States, additional discrete payer categories, such as managed care); and hospital and county identifiers that permit linkage to the American Hospital Association Annual Survey File and the Area Resource File.	ZIP Code	<p>HCUP NIS since 1988</p> <p>HCUP KID since 1997</p> <p>HCUP NEDS since 2006</p> <p>HCUP SID since 1995</p> <p>HCUP SASD since 1997</p> <p>HCUP SEDD since 1999</p>	Yes, data available for purchase: <a href="http://www.hcup-us.ahrq.gov/databases.jsp">http://www.hcup-us.ahrq.gov/databases.jsp</a>	Yes: <a href="http://www.hcup-us.ahrq.gov/reports.jsp">http://www.hcup-us.ahrq.gov/reports.jsp</a>

**Data Source: HIV Costs and Service Utilization Study (HCSUS)** (<http://archive.ahrq.gov/research/findings/factsheets/costs/hcsus/>)

**Brief Description:** The HIV Costs and Service Utilization Study (HCSUS) examined the delivery of health services to people with HIV infection, focusing on access to care, utilization of a wide array of medical services (inpatient, outpatient, antiretroviral medications, mental health), satisfaction with care and quality of life. HCSUS is the only study to obtain a nationally representative U.S. sample of HIV-infected persons receiving medical care. The HCSUS data, however, pertain to an early period in the development of anti-retroviral therapies. The link provided is to archive materials which are no longer maintained.

**Examination Components:** HCSUS conducted three rounds of interviews with HIV-infected patients recruited from multiple clinical service providers across the U.S. The observation period spanned by the three interviews was 18 months. The sample at baseline was 2,864 individuals.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
HIV-infected persons in the U.S. receiving medical care in 1996	Adults	All races/ethnicities	Education; employment; income; assets; health insurance coverage <sup>3</sup>	Indicators of census region (four regions) are available. No finer geographical information is available.	1996-1998	Data from the three interviews with HIV-infected patients are available on public use files; for information, go to <a href="http://www.ahrq.gov">www.ahrq.gov</a> and search for "HCSUS"	There is no single summary report of HCSUS findings. Results have been published in numerous articles in professional journals. Two of the major articles are:  M.F. Shapiro et al. (1999). Variations in the care of HIV-infected adults in the United States. <i>Journal of the American Medical Association</i> , 281(24):2305-2315  S.A. Bozzette et al. (1998). The care of HIV-infected adults in the United States. <i>New England Journal of Medicine</i> , 339, 1897-1904.

<sup>3</sup> Other information provided: Relevant HIV-related clinical information was also obtained (e.g., CD4 and viral load tests, HIV symptoms, treatments).

**Data Source: Medical Expenditure Panel Survey – Household, Insurance and Medical Provider Components (<http://meps.ahrq.gov/mepsweb/>)**

**Brief Description:** The Medical Expenditure Panel Survey (MEPS) collects data on the specific health services that Americans use, how frequently they use them, the cost of these services and how they are paid for, as well as data on the cost, scope and breadth of health insurance held by and available to U.S. workers. MEPS currently has three major components: the Household Component (MEPS-HC), the Medical Provider Component (MEPS-MPC) and the Insurance Component (MEPS-IC). MEPS-HC provides data from individual households and their members, which is supplemented by data from their medical providers. MEPS-IC is a separate survey of employers that provides data on employer-based health insurance. MEPS, which began in 1996, is a set of large-scale surveys of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.) and employers across the country. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage.

**Examination Components:** Nationally representative sample of the civilian noninstitutionalized population of the U.S. MEPS-IC is nationally representative of business establishments in the U.S.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults ages 18 to 90; children ages 0 to 18	Children ages 0 to 18 and adults ages 18 to 90	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Multiple Races	Marital Status, Student Status, Educational Attainment, Military Service and Honorable Discharge, Income, and Poverty Status. <sup>4</sup>	Census tract	1996-present (annual)  Beginning in 2002, the annual sample size for MEPS Household component has been 13,000-15,000 families, the full-year household core response rate has generally been about 66%.	Available from the MEPS website: <a href="http://meps.ahrq.gov/mepsweb/">http://meps.ahrq.gov/mepsweb/</a>	Publications search: This feature is used to access the full text of several types of publications that are based on data collected through MEPS. Reference citations are available for MEPS-related articles in professional journals, research findings, methodology reports, working papers and conference materials <a href="http://meps.ahrq.gov/mepsweb/data_stats/publications.jsp">.http://meps.ahrq.gov/mepsweb/data_stats/publications.jsp</a>

<sup>4</sup> Other variables: MEPS-IC has limited measures of employee characteristics – percent women, percent over 50 and wage categories (information follows).

**Data Source: Medical Expenditure Panel Survey – Insurance Component ([http://meps.ahrq.gov/mepsweb/survey\\_comp/Insurance.jsp](http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp))**

**Brief Description:** The Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) is an annual survey of establishments that collects information about employer-sponsored health insurance offerings in the United States. With MEPSnet/IC, there is easy access to national and state-level statistics and trends about employer-based health insurance. It provides statistics and trends about health insurance offered by private establishments as well as national and regional health insurance estimates for state and local governments. MEPSnet/IC provides guidance through a step-by-step process to obtain the statistics needed. MEPSnet/IC generates statistics using annual data from the MEPS-IC Tables that start in 1996 and are updated each year.

**Examination Components:** The survey features several rounds of interviewing covering two full calendar years. MEPS consists of three components: (1) the Household Component (MEPS-HC), a nationally representative survey of the civilian noninstitutionalized population; (2) the Medical Provider Component (MEPS-MPC), which collects data from medical care providers and facilities reported as providing care to persons interviewed in the MEPS-HC; and (3) the Insurance Component (MEPS-IC), which collects data on the types and costs of workplace health insurance.

MEPS-HC is drawn from a subsample of households that participated in the prior year's National Health Interview Survey conducted by the National Center for Health Statistics. Missing expenditure data are inputted using data collected in the MEPS-MPC whenever possible. The MEPS-MPC collects data from hospitals, physicians, home health care providers and pharmacies that were reported in the MEPS-HC as providing care to MEPS sample persons. The MEPS-MPC is particularly useful in obtaining expenditure information for persons enrolled in managed care plans and for Medicaid recipients. Sample sizes for the MEPS-MPC vary from year to year depending on the MEPS-HC sample size and the MEPS-MPC sampling rates for providers. The Insurance Component (MEPS-IC) consists of two subcomponent samples: a household sample and a list sample. The household sample collects detailed information from employers on the health insurance held by and offered to MEPS-HC respondents. The list sample collects data on the types and costs of workplace health insurance from approximately 40,000 business establishments and governments each year.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. civilian noninstitutionalized population	All ages	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Multiple Races	Sociodemographic characteristics, health care utilization, type of health insurance, sources of payment for health care, health care and medication expenses, and employment status <sup>5</sup>	National estimates	1996-present	Annual 1977 & 1987 National Medical Care Expenditure Surveys; 1996 - present MEPS.	–

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<sup>5</sup> Other variables: health care utilization

**Data Source: National Healthcare Quality Report and National Healthcare Disparities Report**  
 (<http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr11/qrdr11.html>)

**Brief Description:** AHRQ has produced the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) annually since 2003. These reports measure trends in effectiveness of care, patient safety, timeliness of care, patient centeredness and efficiency of care. Chapter topics include care coordination of health system infrastructure. The reports present, in chart form, the latest available findings on quality of and access to health care.

**Examination Components:** The NHQR and NHDR are designed as chart books that contain data on more than 250 health care quality measures from more than 35 databases.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All populations, all ages (depending on data set)	All ages	All races/ethnicities- depending on the data set	Socioeconomic demographics	National, State	Since 2003	Yes; <a href="http://www.ahrq.gov/health-care-information/topics/topic-nhqr.html">http://www.ahrq.gov/health-care-information/topics/topic-nhqr.html</a>  <a href="http://www.ahrq.gov/health-care-information/topics/topic-national-healthcare-disparities-report-nhdr.html">http://www.ahrq.gov/health-care-information/topics/topic-national-healthcare-disparities-report-nhdr.html</a>	Yes, NHQR and NHDR chart books are available yearly



## Department of Health and Human Services Centers for Disease Control and Prevention



**Data Source: Abortion Surveillance Data** ([http://www.cdc.gov/reproductivehealth/Data\\_Stats/index.htm](http://www.cdc.gov/reproductivehealth/Data_Stats/index.htm))

**Brief Description:** The Abortion Surveillance System documents the number and characteristics of women obtaining legal induced abortions, monitors unintended pregnancy, and assists in efforts to identify and reduce preventable causes of morbidity and mortality associated with abortions.

**Examination Components:** For the purpose of surveillance, a legal induced abortion is defined as an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate an ongoing pregnancy. Most states and reporting areas that currently collect abortion data report if an abortion was medical or surgical. States and areas voluntarily report the data to CDC for inclusion in its annual Abortion Surveillance Report. CDC's Division of Reproductive Health prepares surveillance reports as data become available. There is no national requirement for data submission or reporting.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Women of reproductive age	18-65+	White; Black (or African American); Hispanic (or Latino); Asian, Native Hawaiian or Other Pacific Islander (NHPI); American Indian or Alaska Native (AIAN); and Other/Multirace	Household income; education <sup>6</sup>	49 central health agencies in states, New York City and the District of Columbia, and by hospitals and other medical facilities. In general, procedures are reported by the state in which the procedure is performed.	1973-present (periodically)	In addition to the data available in the annual Abortion Surveillance Report, data also are available for abortions distributed by state of maternal residence and state of clinical service. No additional data are available for public use.	Yes, Morbidity and Mortality Weekly Report (MMWR) abortion surveillance reports starting 1979 are available at <a href="http://www.cdc.gov/reproductivehealth/Data_Stats/index.htm">http://www.cdc.gov/reproductivehealth/Data_Stats/index.htm</a>

<sup>6</sup> Other variables: previous live births; period of gestation; and previous induced abortions of women obtaining legal induced abortions.

**Data Source: Alcohol Related Disease Impact System ([http://nccd.cdc.gov/DPH\\_ARDI/default/default.aspx](http://nccd.cdc.gov/DPH_ARDI/default/default.aspx))**

**Brief Description:** The Alcohol Related Disease Impact System (ARDI) is a software system that enables users to produce reports on alcohol-attributable mortality, years of potential life lost (YPLL), health care costs, indirect morbidity and mortality costs, and nonhealth-sector costs associated with alcohol misuse. ARDI includes reports for all 50 states, with options to view each report by gender and age group. In addition, a "custom data" option allows users to produce substate analyses of alcohol-attributable deaths and YPLL.

**Examination Components:** Estimates are calculated for 54 acute and chronic causes using alcohol-attributable fractions and are reported by age and sex .

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Alcohol-attributable mortality	Age categories range from 0-65+	–	–	State	2001-2005	Online research allows the use of a custom data feature to conduct own analyses of alcohol-related harms using the ARDI application .Available at <a href="http://nccd.cdc.gov/DPH_ARDI/default/Default.aspx">http://nccd.cdc.gov/DPH_ARDI/default/Default.aspx</a>	–

**Data Source:** Annual Early Hearing Detection and Intervention Program, Hearing and Screening Follow-Up Survey (<http://www.cdc.gov/ncbddd/hearingloss/ehdi-data.html>)

**Brief Description:** Annual Early Hearing Detection and Intervention (EHDI) programs are located in states and territories, and they are designed to identify infants with hearing loss and enroll these infants in early intervention programs aimed at helping them develop communication skills. The EHDI network collaborates with states in the development and implementation of EHDI programs and assists states in building EHDI data and surveillance systems to ensure that all infants are screened for hearing loss and receive appropriate follow-up services. States report results of screenings and follow-up as part of the annual EHDI survey.

**Examination Components:** Numbers and percent of infants screened for hearing loss, diagnosed with hearing loss and enrolled in intervention programs. Information collected by CDC EHDI reflects data that states and territories have actually documented without any estimation. As a result, data reported by CDC EHDI may differ from other national sources.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Infants	infants	–	–	States, six territories, and the District of Columbia	1999-present Data for years 1999 – 2004 and 2005 and later were collected using different surveys and methods. As a result the data for years 1999 – 2004 is not directly comparable to the data for year 2005 and later.	The Early Hearing Detection and Intervention Data Analysis and Statistical Hub site (EHDI DASH) is an interactive website. Different combinations and charts can be selected to show specific data by year and highlight possible correlations. EHDI	Annual data are available at <a href="http://www.cdc.gov/ncbddd/hearingloss/ehdi-data2013.html">http://www.cdc.gov/ncbddd/hearingloss/ehdi-data2013.html</a>

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
						<p>DASH uses maps, bar charts, line graphs and other tools to show key indicators for states and territories, such as the percent screened for hearing loss or receiving diagnostic testing, and answer other questions. Available at <a href="http://www.cdc.gov/ncbddd/hearingloss/dash-intro.html">http://www.cdc.gov/ncbddd/hearingloss/dash-intro.html</a></p>	

**Data Source: Autism and Developmental Disabilities Monitoring Network (<http://www.cdc.gov/ncbddd/autism/addm.html>)**

**Brief Description:** The Autism and Developmental Disabilities Monitoring (ADDM) Network is a group of programs funded by CDC/National Center on Birth Defects and Developmental Disabilities (NCBDDD) to determine the number of people with autism spectrum disorders (ASDs) in the United States. The network’s goal is to provide comparable, population-based estimates of the prevalence rates of ASD in different sites over time.

**Examination Components:** The network data can provide a population-based description of the characteristics of ASDs, determine differences in ASD prevalence among different population groups and/or geographic regions, and monitor trends in ASD prevalence. The ADDM sites collect data using the same surveillance methods, which are modeled after CDC’s Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with autism	Children	White; Black (or African American); Hispanic (or Latino); Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native; Other/Multirace	–	Currently, 14 states participate in the ADDM Network: Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Maryland, Missouri, New Jersey, North Carolina, Pennsylvania, South Carolina, Utah and Wisconsin	2000-present (annually)	Data and statistics available at <a href="http://www.cdc.gov/ncbddd/autism/data.html">http://www.cdc.gov/ncbddd/autism/data.html</a>	Autism and Development and Disabilities Monitoring (ADDM) <a href="http://www.cdc.gov/ncbddd/autism/addm.html">http://www.cdc.gov/ncbddd/autism/addm.html</a>  Study to Explore Early Development (SEED) <a href="http://www.cdc.gov/ncbddd/autism/seed.html">http://www.cdc.gov/ncbddd/autism/seed.html</a>  Centers for Autism and Developmental Disabilities Research and Epidemiology (CADDRE) <a href="http://www.cdc.gov/ncbddd/autism/caddre.html">http://www.cdc.gov/ncbddd/autism/caddre.html</a>

**Data Source: Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/brfss/>)**

**Brief Description:** The Behavioral Risk Factor Surveillance System (BRFSS) is administered as a telephone interview. Computer-assisted telephone interviewing has been used since 2004. State data may be collected directly by the state health department or through a contractor. In 2007, 12 state health departments collected their data in house; 42 contracted data collection to university survey research centers or commercial firms.

**Examination Components:** Telephone survey: health risk behaviors; preventive health practices; and health care access primarily related to chronic disease and injury. Information is collected on tobacco use, health care coverage, HIV/AIDS knowledge and prevention, physical activity, and fruit and vegetable consumption.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. civilian noninstitutionalized age 18 years and over, residing in households	18-80+	White; Black (or African American); Hispanic (or Latino); Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native; Other	Education; income; health insurance; access to health care; type of insurance	States and metropolitan/ micropolitan areas and Guam	1984-present (annually)	Yes; <a href="http://www.cdc.gov/brfss/data_documentation/">http://www.cdc.gov/brfss/data_documentation/</a>	Yes; <a href="http://www.cdc.gov/brfss/publications/index.htm">http://www.cdc.gov/brfss/publications/index.htm</a>

**Data Source: Breastfeeding Report Card** (<http://www.cdc.gov/breastfeeding/pdf/2009BreastfeedingReportCard.pdf> and [http://healthindicators.gov/Resources/DataSources/Breastfeeding-Report-Card\\_23/Profile](http://healthindicators.gov/Resources/DataSources/Breastfeeding-Report-Card_23/Profile))

**Brief Description:** The CDC Breastfeeding Report Card brings together state-by-state information to help tell the story of breastfeeding practices in states. It compiles many types of data so states can monitor progress, celebrate state successes, and identify opportunities to work with health professionals, employers, business owners, community partners and family members to protect, promote and support breastfeeding.

**Examination Components:** Five indicators profile the extent to which infants in a state are breastfed. Many of these are the breastfeeding goals outlined in Healthy People 2020, a description of the nation’s health priorities. Elements of breastfeeding-friendly communities are measured using indicators, measuring support from birth facilities, health professionals and child care settings.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Mothers and infants in the 50 states and the District of Columbia	Mothers and Infants	–	–	Each indicator is measured in every state, allowing easy state-by-state comparisons.	Reports cards available since 2007	Breastfeeding status at birth, 3, 6, and 12 months; percentage of infants receiving formula before 2 days of age; percentage of births at hospitals identified as Baby-Friendly; laws protecting breastfeeding in public.	Annual report cards, available at <a href="http://www.cdc.gov/breastfeeding/data/reportcard.htm">http://www.cdc.gov/breastfeeding/data/reportcard.htm</a>

**Data Source:** Data Set Directory of Social Determinants of Health at the Local Level ([http://www.cdc.gov/dhdsp/data\\_set\\_directory.htm](http://www.cdc.gov/dhdsp/data_set_directory.htm))

**Brief Description:** The Data Set Directory of Social Determinants of Health at the Local Level contains an extensive list of existing datasets that can be used to address these determinants. The datasets are organized according to 12 dimensions or broad categories of the social environment. Each dimension is subdivided into various components. The 12 dimensions include economy, employment, education, political, environmental, housing, medical, governmental, public health, psychosocial, behavioral and transport.

**Examination Components:** A list of components and data indicators were refined based on conceptual relevance and data availability at the local level. An extensive search for datasets that address each of these components was conducted using traditional and nontraditional sources.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
–	–	–	Income; wealth; poverty; economic development; financial services; cost of living	Metropolitan statistical areas	2004	Dataset references can be found at: <a href="http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf">http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf</a>	–

**Data Source: Disability and Health Data System (<http://dhds.cdc.gov/>)**

**Brief Description:** The innovative Disability and Health Data System (DHDS) tool uses data from the Behavioral Risk Factor Surveillance System (BRFSS) to identify disparities in health between adults with and without disabilities. Through the DHDS, data can be found on a range of health indicators by state in the U.S. and can compare the health of adults with disabilities and adults without disabilities.

**Examination Components:** BRFSS data.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults with and without disabilities	Adults	Hispanic/non-Hispanic; White; Black; Asian; Native Hawaiian; American Indian or Alaska Native; Other/Multirace	Income; education; employment status; veteran status; health risk and behaviors; barriers and costs of health care	State	2004-2012	Available publicly at: <a href="http://dhds.cdc.gov/dataviews/">http://dhds.cdc.gov/dataviews/</a>  Most data displayed in DHDS come from the Behavioral Risk Factor Surveillance System (BRFSS). Additional data sources used to calculate disability-associated health care expenditures are: the National Health Interview Survey (NHIS), the Medical Expenditure Panel Survey (MEPS), and the National Health Expenditure Accounts (NHEA).	Maps and Data Tables are available and allow generation of reports, at <a href="http://dhds.cdc.gov/dataviews/">http://dhds.cdc.gov/dataviews/</a>

**Data Source: Electronic Report of Verified Case of Tuberculosis (<http://www.cdc.gov/tb/programs/tims/NEDSS.htm>)**

**Brief Description:** The Report of Verified Case of Tuberculosis is the national TB surveillance system. Data are collected by state and local TB programs and are submitted electronically to CDC, Division of Tuberculosis Elimination (DTBE). These data are used to monitor national TB trends, identify priority needs, and create the DTBE Annual Surveillance Report.

**Examination Components:** In January 1993, an expanded system was developed to collect additional information for each reported TB case to better monitor trends in TB and TB control. A software package (SURVS-TB) for data entry, analysis and transmission of case reports to CDC was designed and implemented as part of the expanded TB surveillance system. In 1998, the Tuberculosis Information Management System (TIMS) replaced SURVS-TB. In total, 11,182 TB cases were reported in the United States in 2010.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with tuberculosis	All	All races and ethnicities	–	Reports of verified cases of tuberculosis are submitted to DTBE by 60 reporting areas (the 50 states, the District of Columbia, New York City, Puerto Rico and 7 jurisdictions in the Pacific and Caribbean).	See availability for use information and periodic reports	Tuberculosis incidence in the United States by year (1953-2014) is available at <a href="http://www.cdc.gov/tb/statistics/tbcases.htm">http://www.cdc.gov/tb/statistics/tbcases.htm</a>	Reported tuberculosis in the United States, 2014, available at <a href="http://www.cdc.gov/tb/statistics/reports/2014/default.htm">http://www.cdc.gov/tb/statistics/reports/2014/default.htm</a>

**Data Source: Emerging Infections Program Network (<http://www.cdc.gov/nceid/dpei/eip/>)**

**Brief Description:** The Emerging Infections Program (EIP) network is a network of 10 state health departments (California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, Oregon and Tennessee) and their collaborators in local health departments, academic institutions, other federal agencies and public health and clinical laboratories; infection preventionists; and health care providers formed to conduct active, laboratory-based surveillance among defined populations, conduct applied public health epidemiologic and laboratory activities, and implement and evaluate pilot prevention and intervention projects.

**Examination Components:** The network comprises a catchment area of approximately 44 million people, though this varies by project.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
–	–	The EIP population is roughly representative of the U.S. population on the basis of demographic characteristics such as age, gender, race, and urban residence, as well as health indicators. <sup>7</sup>	Percent at or below the poverty level <sup>7</sup>	State (CA, CO, CT, GA, MD, MN, NM, NY, OR, TN)	1995-2011	Data and statistics available at <a href="http://www.cdc.gov/tb/statistics/default.htm">http://www.cdc.gov/tb/statistics/default.htm</a>	EIP publication resources available at <a href="http://www.cdc.gov/nceid/dpei/eip/eip-publications.html">http://www.cdc.gov/nceid/dpei/eip/eip-publications.html</a>

<sup>7</sup> Other information provided: Health indicators address population density and percent at or below the poverty level.

**Data Source: Foodborne Diseases Active Surveillance Network (<http://www.cdc.gov/foodnet/>)**

**Brief Description:** The Foodborne Diseases Active Surveillance Network (FoodNet) has been tracking trends for infections commonly transmitted through food since 1996. FoodNet provides a foundation for food safety policy and prevention efforts. It estimates the number of foodborne illnesses in the United States through active surveillance and epidemiologic studies; monitors trends in incidence of specific foodborne illnesses over time; attributes illnesses to specific foods and settings; and disseminates this information. FoodNet conducts surveillance for *Campylobacter*, *Cryptosporidium*, *Cyclospora*, *Listeria*, *Salmonella*, Shiga toxin-producing *Escherichia coli* (STEC) O157 and non-O157, *Shigella*, *Vibrio* and *Yersinia* infections diagnosed by laboratory testing of samples from patients.

As the principal foodborne disease component of CDC's Emerging Infections Program, FoodNet is a collaborative program among CDC, 10 state health departments, the U.S. Department of Agriculture's Food Safety and Inspection Service (USDA-FSIS) and the Center for Food Safety and Applied Nutrition of the U.S. Food and Drug Administration (FDA). FoodNet personnel located at state health departments regularly contact the clinical laboratories in Connecticut, Georgia, Maryland, Minnesota, New Mexico, Oregon and Tennessee and selected counties in California, Colorado and New York to collect reports of infections diagnosed in residents of these areas. The surveillance area includes 15 percent of the U.S. population (47 million persons).

**Examination Components:** FoodNet personnel within each site contact clinical laboratories within that site's catchment area at least once a month to ascertain all laboratory-confirmed cases of infection. A case report form is completed for each case, which includes information on demographics, clinical outcomes and the pathogen. Laboratory audits to assess completeness of data and to ascertain additional cases are conducted. All rates are calculated using population estimates for the appropriate years. Other information provided includes incidence of infection by age group and organism.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Surveillance areas represent 42 million persons; 14% of the U.S. population. (Source: U.S. Census Bureau)	Ages less than 1 year to older adults (65 years and older)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Multiple	Incidence of infection by age group and organism	National	Annually dependent upon data category: 1997-2012	Publicly available at: <a href="http://www.cdc.gov/foodnet/">http://www.cdc.gov/foodnet/</a> or <a href="http://www.cdc.gov/ncezid/dfwed/edeb/reports.html">http://www.cdc.gov/ncezid/dfwed/edeb/reports.html</a>	Morbidity and Mortality Weekly Report (MMWR), 1996-2012; Morbidity and Mortality Weekly Report (Q&As), 2006-2010 & 2012; Annual Report Tables, 1997-2004; Annual Reports-Final Data, 1997-2011; Atlas of Exposures, 2002-2007; Other reports, 2003 & 2006-2007; 2003 FoodNet Annual Report.

**Data Source: Longitudinal Studies of Aging (<http://www.cdc.gov/nchs/lsoa.htm>)**

**Brief Description:** The Longitudinal Studies of Aging (LSOA) is a multicohort study designed to measure change in health status, health-related behaviors and health care, and the causes and consequences of these changes within and across two cohorts of elderly Americans. A second objective of the study is to provide a mechanism for monitoring the impact of proposed changes in Medicare and Medicaid and the accelerating shift toward managed care on the health status of the elderly and their patterns of health care utilization. The LSOA is comprised of the following components:

- Supplement on Aging, 1984 (SOA)
- Longitudinal Studies of Aging, 1984-1990 (LSOA)
- Second Supplement on Aging, 1995 (SOA II)
- Second Longitudinal Studies of Aging, 1995, 1997 (LSOA II)

The Supplement on Aging (SOA) was conducted as part of the 1984 National Health Interview Survey (NHIS). The SOA was based on a national sample of 16,148 persons, 55 years of age and older, living in the community. Interviews for the SOA were conducted in person by the U.S. Census Bureau. The 1984 SOA served as the baseline for the LSOA, which followed all persons who were 70 years of age or over in 1984 through three follow-up waves in 1986, 1988 and 1990. All follow-up interviews were conducted over the telephone by interviewers from the Census Bureau. The major focus of the follow-up interviews was on functional status and changes that had occurred between interviews, although information was also collected on housing and living arrangements, contact with children, utilization of health services and nursing home stays, health insurance coverage and income. The interview data was augmented by linkage to Medicare records, the National Death Index and multiple cause-of-death records.

The Second Supplement on Aging (SOA II) was conducted as part of the 1994 NHIS. Interviews for the SOA II were conducted during a follow-up visit with NHIS respondents between October 1994 and March 1996. The SOA II sample is comprised of approximately 9,447 persons who had participated in the 1994 NHIS and had turned 70 years of age by the time of the SOA II interview. SOA II serves as a comparison cohort to the 1984 SOA, and most of the questions from the SOA were repeated in the SOA II. The SOA II provides the baseline for the second LSOA. Data collection for the first follow-up wave of the LSOA II began in May, 1997; future follow-up waves were conducted at two-year intervals. Many of the questions included in the SOA II are repeated in the follow-up interview. In addition, the follow-up questionnaire includes more extensive information on cognitive and affective functioning, health care utilization, unmet health care needs and health insurance. The amount of health service utilization data provided through linkage to Medicare records greatly expanded what had been available in the first LSOA.

**Examination Components:** The following topics were covered in the interview:

Housing characteristics:

- Family structure and living arrangements

- Relationships and social contacts
- Use of community services
- Occupation and retirement (income sources)
- Health conditions and impairments
- Functional status, assistance with basic activities
- Utilization of health services, nursing home stays

Health opinions. Topics new to the SOA II include:

- Use of assistive devices and medical implants
- Health conditions and impairments
- Health behaviors
- Transportation
- Functional status, assistance with basic activities, unmet needs (expanded)
- Utilization of health services, nursing home stays (expanded)

The LSOA is comprised of the following components:

- Supplement on Aging, 1984 (SOA)
- Longitudinal Studies of Aging, 1984-1990 (LSOA)
- Second Supplement on Aging, 1995 (SOA II)
- Second Longitudinal Studies of Aging, 1995, 1997 (LSOA II)

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
<p>Elderly Americans</p> <p>(1) The Supplement on Aging (SOA) was conducted as part of the 1984 National Health Interview Survey (NHIS). The SOA was based on a national sample of 16,148 persons, 55 years of age and older, living in the community.</p> <p>(2) The 1984 SOA served as the baseline for the Longitudinal Study of Aging (LSOA), which followed all persons who were 70 years of age and over in 1984 through three follow-up waves—in 1986, 1988, and 1990.</p> <p>(3) The Second Supplement on Aging (SOA II) was conducted as part of the 1994 NHIS. The SOA II sample is comprised of approximately 9,447 persons who had participated in the 1994 NHIS and had turned 70 years of age by the time of the SOA II interview.</p> <p>(4) The SOA II provides the baseline for the Second Longitudinal Study of Aging (LSOA II). The LSOA II is a prospective study with a nationally representative sample comprised of 9,447 civilian noninstitutionalized persons 70 years of age and over at the time of their SOA II interview.</p>	Older adults ages 55+ or 70+ (varies by survey)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Housing characteristics; family structure and living arrangements; occupation and retirement (income sources); transportation <sup>8</sup>	National	1984-2000	1984 SOA: <a href="http://www.cdc.gov/nchs/lsoa/soa1.htm#data">http://www.cdc.gov/nchs/lsoa/soa1.htm#data</a> 1984-1990 LSOA, 1994 SOA II, and 1994-2000 LSOA II: Yes, available upon request; to request a copy of the CD-ROM or diskettes, email: <a href="mailto:nchsquery@cdc.gov">nchsquery@cdc.gov</a> or telephone (301) 458-INFO	1984 SOA: <a href="http://www.cdc.gov/nchs/data/series/sr_01/sr01_021.pdf">http://www.cdc.gov/nchs/data/series/sr_01/sr01_021.pdf</a> 1984-1990 LSOA: <a href="http://www.cdc.gov/nchs/data/series/sr_01/sr01_028.pdf">http://www.cdc.gov/nchs/data/series/sr_01/sr01_028.pdf</a> 1994 SOA II and 1994-2000 LSOA II: None

<sup>8</sup> Other variables: functional status, assistance with basic activities, unmet needs (expanded); utilization of health services, nursing home stays (expanded); relationships and social contacts; use of community services; health conditions and impairments; functional status, assistance with basic activities; utilization of health services, nursing home stays; health opinions; use of assistive devices and medical implants; health conditions and impairments; health behaviors.

**Data Source: HIV Surveillance System** ([http://www.healthindicators.gov/Resources/DataSources/NHSS\\_57/Profile](http://www.healthindicators.gov/Resources/DataSources/NHSS_57/Profile))

**Brief Description:** CDC'S HIV Surveillance System is the nation's source for timely information used to track the epidemic. CDC funds and assists state and local health departments to collect the information. Health departments report their data to CDC so that information from around the country can be analyzed to determine who is being affected and why. For details on confidentiality of surveillance data, see Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action.

**Examination Components:** HIV reporting provides information on demographic characteristics (i.e. sex, race/ethnicity, age and place of diagnosis), transmission category (mode of exposure), initial immune status and viral load. As of April 2008, 57 areas had laws or regulations requiring confidential reporting by name for adults, adolescents and children with confirmed HIV infection (not AIDS) in addition to the reporting of people with AIDS.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All 50 states, the District of Columbia, and U.S. territories	–	–	Data include demographic characteristics, living status, mode of exposure to HIV, case definition category, and other clinical information.	All 50 States, the District of Columbia, and U.S. territories report AIDS cases to CDC by using a uniform surveillance case definition and case report form. The original definition was modified in 1985 and 1987. The case definition for adults and adolescents was modified again in 1993.	Annual, 1981-present	The National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) Atlas was created to provide an interactive platform for accessing data collected by CDC's National Center for HIV/AIDS and other conditions. Available at <a href="http://www.cdc.gov/nchhstp/atlas/index.htm">http://www.cdc.gov/nchhstp/atlas/index.htm</a>	HIV surveillance Reports available at <a href="http://www.cdc.gov/hiv/library/reports/surveillance/">http://www.cdc.gov/hiv/library/reports/surveillance/</a>

**Data Source: Medical Monitoring Project** (<http://www.cdc.gov/hiv/topics/treatment/mmp/index.htm>)

**Brief Description:** The Medical Monitoring Project (MMP) is a surveillance project designed to learn more about the experiences and needs of people who are receiving care for HIV. It is conducted by state and local health departments with funding and support from CDC/National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP).

**Examination Components:** Patient interviews and medical record abstraction are conducted to ascertain patient demographic characteristics, income, health insurance coverage, method of payment for HIV-related drugs, met and unmet HIV-related care needs and HIV care outcomes.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults receiving care for HIV in the U.S. A sample of 16 states, 6 separately funded cities within those states, and 1 territory were selected from among the 50 states.	Young adults (18 years to 24 years); adults (25 years to 64; and older adults (65 years and older)	Hispanic; Latino/a; Spanish Origin (Mexican, Mexican American or Chicano/a, Puerto Rican, Cuban, Another Hispanic, Latino/a, Spanish origin); American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White	Income; education level; homelessness; incarceration; health insurance coverage; method of payment for HIV-related drugs; met and unmet HIV-related care needs <sup>9</sup>	16 states (California, Delaware, Florida, Georgia, Illinois, Indiana, Michigan, Mississippi, North Carolina, New Jersey, New York, Oregon, Pennsylvania, Texas, Virginia, Washington); 6 separately funded cities within those states (Chicago, Houston, Los Angeles, New York city, Philadelphia, San Francisco; and 1 territory (Puerto Rico)	2005-present (annually)	Datasets are not publicly available because they are covered by CDC's Assurance of Confidentiality related to HIV-surveillance data. Weighted estimates for variables of interest are published in reports from each year of data collection.	Division of HIV/AIDS Prevention surveillance special reports  Morbidity and Mortality Weekly Report (MMWR) surveillance summaries

<sup>9</sup> Other information provided: HIV care outcomes.

**Data Source: Morbidity and Mortality Weekly Report ( <http://www.cdc.gov/mmwr/index.html> )**

**Brief Description:** The Morbidity and Mortality Weekly Report (MMWR) series, prepared by CDC, is often called “the voice of CDC.” MMWR is CDC’s primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective and useful public health information and recommendations.

**Examination Components:** The data in the weekly MMWR are provisional, based on weekly reports to CDC by state health departments. MMWR readership predominantly consists of physicians, nurses, public health practitioners, epidemiologists and other scientists, researchers, educators and laboratorians.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
–	–	–	–	–	–	Weekly reports available at <a href="http://www.cdc.gov/mmwr/index2015.html">http://www.cdc.gov/mmwr/index2015.html</a>	Weekly reports; recommendations and reports; surveillance summaries

**Data Source: National Ambulatory Medical Care Survey (<http://www.cdc.gov/nchs/ahcd.htm>)**

**Brief Description:** The National Ambulatory Medical Care Survey (NAMCS) is an annual survey that collects visit practice- and provider-level data from office-based physicians and community health center providers in the United States. Field personnel meet with participating office-based physicians and instruct them in survey data collection methods. Physicians are asked to complete a one-page questionnaire (patient record form) on a sample of their office visits during their assigned reporting period. However, more than half of NAMCS patient record forms submitted in 2008 (53.8 percent) were abstracted by field personnel from the U.S. Census Bureau rather than by the physician or medical office personnel.

**Examination Components:** Review of medical records for patient visits; interviews with hospital administrators. Additional information collected includes patient demographics, diagnoses, procedures and medications; provider/clinician characteristics (practice size, ownership); and use of electronic medical records.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
20,000-35,000 patient visits annually from 2,200-2,500 physicians in office-based practices or community health centers	Infants/toddler s; children; youth (early teens to 18); young adults (18 years to 24); adults (25 years to 64years); and older adults (65 years and older)	Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	OMB categories. Patient characteristics and clinical management. Patient demographics, diagnoses, procedures, and medications. Providers/clinician characteristics, specially, practice size, ownership, and use of electronic medical records.	Region	Annual since 2010	Publicly available at: <a href="http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm">http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm</a>  Restricted variables available through the Research Data Center: <a href="http://www.cdc.gov/rdc/">http://www.cdc.gov/rdc/</a>	Yes; annual summary tables online and periodic topic-focused reports

**Data Source:** National Ambulatory Medical Care Survey, National Electronic Health Records Survey (<http://www.cdc.gov/nchs/ahcd.htm>)

**Brief Description:** The National Ambulatory Medical Care Survey (NAMCS), Electronic Medical Records (EMR) supplement, which began in 2008, is a mail survey designed to collect information on the use of EMR systems and the availability of specific computerized functionalities in physician offices. In 2008 and 2009, the mail survey shared the same sampling files as the in-person NAMCS. Starting in 2010, the EMR mail survey sample was selected from the 50 states and the District of Columbia to provide state-level estimates. Data from the mail survey are available in one file, and a second file is available which combines data from both the mail survey and the in-person NAMCS. The EMR supplement became the National Electronic Health Records Survey starting in 2012.

**Examination Components:** Physician survey.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Physicians	Adults (25 years to 64 and older adults (65 years and older)	Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	Use of electronic medical records/features-based practices; specialty, practice size, ownership	States	1973 to 1981, in 1985, and annually since 1989	Publicly available at: <a href="http://www.cdc.gov/nchs/ahcd.htm">http://www.cdc.gov/nchs/ahcd.htm</a>  Research Data Center website: <a href="http://www.cdc.gov/rdc/">http://www.cdc.gov/rdc/</a>	Yes

**Data Source:** National Ambulatory Medical Care Survey – Physician Workflow Survey ([http://www.cdc.gov/nchs/ahcd/ahcd\\_questionnaires.htm](http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm))

**Brief Description:** The National Ambulatory Medical Care Survey (NAMCS) Physician Workflow Supplement was a survey follow-up data collection initiative sponsored by the Office of the National Coordinator for Health Information Technology to provide a better understanding of physician experiences with adoption and use of electronic health records.

**Examination Components:** Mail survey of office-based physicians.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
5,600 physicians	Adults (25 years to 64 years) and older adults (65 years and older)	Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	Provider characteristics; use of electronic medical records and features; specialty, practice size, ownership; facility characteristics; physicians attitudes about electronic health records, barriers, benefits and impact	ZIP code	2011-2013	Publicly available at: <a href="http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm">http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm</a>  Research Data Center website: <a href="http://www.cdc.gov/rdc/">http://www.cdc.gov/rdc/</a>	Yes; summary statistics

**Data Source: National Environmental Public Health Tracking Network (<http://ephtracking.cdc.gov/showHome.action>)**

**Brief Description:** The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure and hazard information and data from a variety of national, state and city sources.

On the Tracking Network, maps, tables and charts with data are available about:

- Chemicals and other substances found in the environment
- Some chronic diseases and conditions
- The area where you live

**Examination Components:** Specifically, the Tracking Network provides information about the following types of data:

- Health effect data: Data about health conditions and diseases, such as asthma and birth defects.
- Environmental hazard data: Data about chemicals or other substances such as carbon monoxide and air pollution in the environment.
- Exposure data: Data about the amount of a chemical in a person’s body, such as lead in blood.
- Other data: Data about relationships between exposures and health effects. For example, information about age, sex, race and behavior or lifestyle choices that help advance understanding about why a person has a particular health problem.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
–	–	–	–	CDC provides funds to 26 state and local health departments to develop local tracking networks, which feed into the National Tracking Network.	–	Data and available programs can be tracked at <a href="http://ephtracking.cdc.gov/QueryPanel/EPHTNQuery/EPHTQuery.html?c=-1&amp;i=-1&amp;m=-1">http://ephtracking.cdc.gov/QueryPanel/EPHTNQuery/EPHTQuery.html?c=-1&amp;i=-1&amp;m=-1</a>	Reports and findings can be generated through the reporting tool

**Data Source: National Health Interview Survey (<http://www.cdc.gov/nchs/nhis.htm>)**

**Brief Description:** The National Health Interview Survey (NHIS) has monitored the health of the nation since 1957. NHIS data on a broad range of health topics are collected through in-person household interviews conducted by the U.S. Census Bureau. Survey results have been instrumental in providing data to track health status, health care access, health insurance coverage and progress toward achieving national health objectives. The NHIS is a primary source of data for analyzing health trends and determining barriers to care by comparing health status, health-related behaviors and risk factors across racial and ethnic populations. Reports on key indicators are released quarterly, and a Public Use File is released annually. Although primarily a source for national data, estimates can be made for most states.

**Examination Components:** Personal interviews of 35,000 to 51,000 households per year .

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nonmilitary, non-institutionalized population	All age groups	White, Black/African American; American Indian/Alaska Native; Asian Other Race Multiple Races. <sup>10</sup>	Family and individual income; income; poverty level; type of living quarters; education and occupation; utilizations health care; health insurance; access to care <sup>11</sup>	The sampling plan is redesigned after every decennial census. The current sampling plan was implemented in 2006. It has many similarities to the previous sampling plan, which was in place from 1995 to 2005. The first stage of the current sampling plan consists of a sample of 428 primary sampling units (PSUs) drawn from approximately 1,900 geographically defined PSUs that cover the 50 states and the District of Columbia. A PSU consists of a county, a small group of contiguous counties or a metropolitan statistical area. Within a PSU, two types of second-stage units are used: area segments and permit segments. Area segments are defined geographically and contain an expected 8, 12, or 16 addresses. Permit segments cover housing units built after the 2000 census. The permit segments are defined using updated lists of building permits issued in the PSU since 2000 and contain an expected four addresses.	1957-collected on annual basis	Public Use Files, usable without restrictions	<a href="http://www.cdc.gov/nchs/data/factsheets/factsheet_nhis.htm">http://www.cdc.gov/nchs/data/factsheets/factsheet_nhis.htm</a>

<sup>10</sup>Data are gathered on additional race categories (Native Hawaiians, Guamanian, Samoan, Other Pacific Islanders, Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese) which are not included on the Public Use File for confidentiality reasons.

<sup>11</sup> Other information: acculturation questions/language used during interview; citizenship status; health status and limitations; poisoning and injuries; selected health conditions; health behaviors; functioning/disability; immunizations; birthplace.

**Data Source:** National Health and Nutrition Examination Survey (<http://www.cdc.gov/nchs/nhanes.htm>)

**Brief Description:** The National Health and Nutrition Examination Survey (NHANES) operates out of mobile examination centers that travel to randomly selected sites throughout the country to assess the health and nutritional status of Americans. This survey combines personal interviews with standardized physical examinations, diagnostic procedures and laboratory tests to obtain information about diagnosed and undiagnosed conditions; growth and development, including overweight and obesity; diet and nutrition; risk factors; and environmental exposures.

**Examination Components:** Personal interviews; physical examinations; laboratory tests; nutritional assessment; DNA repository.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All ages	American Indian or Alaska Native; Asian; Black or African American; White; Other; Mexican American, Hispanic/Latino/Spanish Origin or Ancestry <sup>12</sup>	Income and poverty index; education; occupation; type of living quarters; social services	National	Periodic cross-sectional NHANES surveys 1971-1974; 1976-1980; 1982-1984 (Hispanic HANES); 1988-1994; Beginning 1999- collected annually, with capability for linking to other databases (i.e., mortality, Medicare)	Yes	<a href="http://www.cdc.gov/nchs/nhanes/nhanes_products.htm">http://www.cdc.gov/nchs/nhanes/nhanes_products.htm</a>

<sup>12</sup> Other ethnicity variables include follow-up questions on race/ethnicity response categories by country of origin or ancestry.

**Data Source: National HIV Behavioral Surveillance System** (<http://www.cdc.gov/hiv/dhap/bcsb/nhbs/index.html>)

**Brief Description:** The primary purpose of the National HIV Behavioral Surveillance (NHBS) system is to monitor the HIV epidemic through an ongoing HIV behavioral surveillance system. This system ascertains the prevalence of and trends in HIV risk behaviors and HIV infection among groups at high risk for HIV infection. Information from the system is used to develop and direct the evaluation of national and local HIV prevention services and programs. The system focuses on the three populations at highest risk: men who have sex with men; injectable drug users; and heterosexuals at increased risk of HIV. The project collects information from these three populations in rotating 12-month cycles.

**Examination Components:** Core interview questions include demographics, sexual behavior, injection and noninjection drug use, HIV testing and use of prevention services. Each local site has the option to conduct a short adjunct survey with specific questions related to access and use of local HIV services.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Populations at risk for HIV: men who have sex with men, injection drug users, heterosexuals at increased risk of HIV	Young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	Black (non-Hispanic); Hispanic; White (non-Hispanic); Other/Multiple Races (other races include American Indian/Alaska Native; Asian; Native Hawaiian/Other Pacific Islander; and Mixed Race)	Income and poverty index; education; occupation status; marital status; homelessness; health insurance <sup>13</sup>	Metropolitan statistical areas with high AIDS prevalence	2003-present	Datasets are not publicly available because they are covered by CDC's Assurance of Confidentiality related to HIV surveillance data. Aggregate data from each cycle are made available to the public via published reports.	Division of HIV/AIDS Prevention surveillance special reports, surveillance summaries, Morbidity and Mortality Weekly Reports (MMWR)

<sup>13</sup> Other information provided: birthplace; acculturation questions regarding language usually spoken at home; selected diseases and conditions including HIV and STDs; perceived community tolerance and stigma; drug use.

**Data Source: National Home Health Aide Survey (<http://www.cdc.gov/nchs/nhhas.htm>)**

**Brief Description:** National Home Health Aide Survey (NHHAS), the first national probability survey of home health aides, was designed to provide national estimates of home health aides employed by agencies that provide home health and/or hospice care. NHHAS was sponsored by the Office of the Assistant Secretary for Planning and Evaluation. A multistage probability sample survey, NHHAS was conducted as a supplement to the 2007 National Home and Hospice Care Survey (NHHCS). Agencies providing home health and/or hospice care were sampled into NHHCS, and then up to six home health aides were sampled from eligible participating NHHCS agencies. Home health aides were considered eligible to participate in NHHAS if they:

1. Were directly employed by the sampled agency; and
2. Provided assistance in activities of daily living, including bathing, dressing, transferring, eating and toileting.

**Examination Components:** NHHAS was administered to aides during their nonworking hours by interviewers who used a computer-assisted telephone interviewing system to collect the data. The survey instrument included sections on recruitment, training, job history, family life, management and supervision, client relations, organizational commitment and job satisfaction, workplace environment, work-related injuries and demographics. The NHHAS questionnaire was virtually identical to the survey instrument used in the 2004 National Nursing Assistant Survey of certified nursing assistants working in nursing homes in order to permit comparisons of direct care workers across long-term care workplace settings. Minor changes were made to account for differences in workplace environment and responsibilities between home health aides and certified nursing assistants. A total of 3,377 interviews of aides working in agencies providing home health and/or hospice care were completed between September 2007 and April 2008. A detailed methods report on the 2007 NHHAS is available on the NHHCS website (<http://www.cdc.gov/nchs/nhhcs.htm>).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
4,416 home health aide cases were sampled	N/A	Hispanic/Latino; American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Other Race	Gross income before taxes; employment; education; full/part-time employment	ZIP code	2007	Some variables available on Public Use File: <a href="http://www.cdc.gov/nchs/nhhas.htm">http://www.cdc.gov/nchs/nhhas.htm</a>	2007 summary report: <a href="http://www.cdc.gov/nchs/data/nhsr/nhsr034.pdf">http://www.cdc.gov/nchs/data/nhsr/nhsr034.pdf</a>

**Data Source: National Home and Hospice Care Survey** (<http://www.cdc.gov/nchs/nhhcs.htm>)

**Brief Description:** The 2007 National Home and Hospice Care Survey (NHHCS) is one in a continuing series of nationally representative sample surveys of U.S. home health and hospice agencies. It is designed to provide descriptive information on home health and hospice agencies, their staffs, their services and their patients. NHHCS was first conducted in 1992 and was repeated in 1993, 1994, 1996, 1998 and 2000. Conducted between August 2007 and February 2008, NHHCS was reintroduced into the field in 2007 after a seven-year break. During that time, the survey was redesigned and expanded to include a computer-assisted personal interviewing system, many new data items and larger sample sizes of current home health patients and hospice discharges. All agencies that participated in the survey were either certified by Medicare or Medicaid or were licensed by a state to provide home health or hospice services and currently or recently served home health or hospice patients. The survey excluded agencies that provided only homemaker services or housekeeping services, assistance with instrumental activities of daily living or durable medical equipment and supplies. The 2007 NHHCS included a supplemental survey of home health aides employed by home health and hospice agencies called the National Home Health Aide Survey.

**Examination Components:** The 2007 NHHCS data were collected through in-person interviews with agency directors and their designated staffs; no interviews were conducted directly with patients or their families/friends.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Home health patients and hospice discharges; available in medical records; included age, sex, race, and ethnicity; services received; length of time since admission; diagnoses; medications taken; advance directives; and many other items	Adults	White; African American/ Black; American Indian/Alaska Native; Asian; Native Hawaiian/ Pacific Islander; Other	Income before taxes; employment; education; full/part-time employment	Home health agencies in different locations	NHHCS was first conducted in 1992 and was repeated in 1993, 1994, 1996, 1998 and 2000, and most recently in 2007.	Yes <a href="http://www.cdc.gov/nchs/nhhcs/nhcs_questionnaires.htm">http://www.cdc.gov/nchs/nhhcs/nhcs_questionnaires.htm</a>	<a href="http://www.cdc.gov/nchs/nhhcs.htm">http://www.cdc.gov/nchs/nhhcs.htm</a>

**Data Source: National Hospital Ambulatory Medical Care Survey** ([http://www.cdc.gov/nchs/ahcd/about\\_ahcd.htm](http://www.cdc.gov/nchs/ahcd/about_ahcd.htm) and [http://www.cdc.gov/nchs/ahcd/ahcd\\_questionnaires.htm](http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm))

**Brief Description:** The National Hospital Ambulatory Medical Care Survey (NHAMCS) collects data on the utilization and provision of medical care services provided in hospital emergency (ED) and outpatient departments (OPD). Specially trained interviewers visit facilities prior to their participation in the survey to explain survey procedures, verify eligibility, develop a sampling plan and train staff in data collection procedures. The survey instrument is the patient record form, which is provided in three versions – one for the emergency department, one for the outpatient department and one for the ambulatory surgery facilities. Staff are instructed to complete patient record forms for a systematic random sample of patient visits during a randomly assigned four-week reporting period. Data are obtained on demographic characteristics of patients; expected source(s) of payment; patients' complaints; diagnoses; diagnostic/screening services; procedures; medication therapy; disposition; types of providers seen; causes of injury (emergency department and ambulatory surgery center only); and certain characteristics of the facility, such as geographic region and metropolitan status.

**Examination Components:** Review and collect data from medical records on patient visits; interview hospital administrators. Hospital staff are asked to complete a patient record form for a sample of patient visits during an assigned reporting period. NHAMCS patient record form is modified approximately every two to four years to reflect changes in physician practice characteristics, patterns of care and technological innovations.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
30,000-35,5000 patient visits for ED component and 30,000-35,5000 patient visits for the OPD component annually; 480 hospitals with EDs, outpatient departments, or ambulatory surgery locations; 200 freestanding ambulatory surgery centers	Infants/toddlers, children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	Hispanic/Latino, White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	Patient residence; expected sources of payment for visit	Region	Annual; 1992-present	Publicly available at: <a href="http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm">http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm</a>  Restricted variables available through the Research Data Center: <a href="http://www.cdc.gov/rdc/">http://www.cdc.gov/rdc/</a>	Tips for using NHAMCS research tools available at <a href="http://www.cdc.gov/nchs/ahcd/ahcd_research_tools.htm">http://www.cdc.gov/nchs/ahcd/ahcd_research_tools.htm</a>  Survey results and publications available at <a href="http://www.cdc.gov/nchs/ahcd/ahcd_products.htm">http://www.cdc.gov/nchs/ahcd/ahcd_products.htm</a>

**Data Source: National Hospital Care Survey (<http://www.cdc.gov/nchs/nhcs.htm>)**

**Brief Description:** This new survey integrates inpatient data formerly collected by the National Hospital Discharge Survey with the ED, OPD, hospital-based ambulatory surgery location (ASL), and freestanding ambulatory surgery center (ASC) data collected by the National Hospital Ambulatory Medical Care Survey. The integration of these two surveys allows examination of care provided across treatment settings. It will also be possible to link the survey data to the National Death Index and the Medicare Provider Analysis and Review (MedPAR) and Medicaid Statistical Information System (MSIS) datasets to obtain a more complete picture of patient care. This survey will replace the Hospital Discharge Survey.

**Examination Components:** Linkage to NDI and CMS data, hospital records, and all UB04 elements.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Sample of 500 hospitals	Infants/toddlers; children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	N/A	OMB categories: utilization of hospital care; inpatient care; and care delivered in EDs, OPDs, hospital-based and/or free standing ASCs	Region	Ongoing	–	–

**Data Source: National Hospital Discharge Survey** (<http://www.cdc.gov/nchs/nhds.htm>)

**Brief Description:** The National Hospital Discharge Survey (NHDS), which was conducted annually from 1965-2010, was a national probability survey designed to meet the need for information on characteristics of inpatients discharged from nonfederal, short-stay hospitals in the United States. Data from the NHDS are available annually and are used to examine important topics of interest in public health and for a variety of activities by governmental, scientific, academic and commercial institutions. This survey will be replaced by the National Hospital Care Survey.

**Examination Components:** Manual sample selection and abstraction of data from inpatient medical records by field personnel or automated data collection through purchase of electronic files from commercial abstracting sources, states or hospitals.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nationally representative sample of nonfederal hospitals with an average length of stay; 30 days for all inpatients, general hospitals and children; units of institutions (e.g., prisons)	Infants/toddlers; children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	White; Black or African American; American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander; Other; Not Stated; Hispanic or Latino; Not Hispanic or Latino; Not Stated	Utilization of hospital care; inpatient care	Region	Annual; 1965-2010	Yes; <a href="http://www.cdc.gov/nchs/nhds.htm">http://www.cdc.gov/nchs/nhds.htm</a>	Annually until 2010

**Data Source: National Immunization Survey (<http://www.cdc.gov/nchs/nis.htm>)**

**Brief Description:** The National Immunization Survey (NIS) is a continuing nationwide telephone sample survey to monitor vaccination coverage rates among children ages 19-35 months. Starting in 2006, NIS-Teen was established to collect similar information for adolescents ages 13-17 years. NIS-Teen was conducted for a national sample in the fourth quarters of 2006 and 2007 and expanded to an annual sample in each of 56 or more state and local geographic areas starting in 2008. The first stage of survey administration is conducted using telephone interviews with households having age-eligible children. In the second stage, provider reports of vaccination information from the child’s medical record are obtained.

**Examination Components:** Target population for the NIS is children between the ages of 19 and 35 months living in the United States at the time of the interview. The NIS is a list-assisted, random-digit-dialing telephone survey followed by a mailed survey to children’s immunization providers.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children <sup>14</sup>	19-35 months	White; Black/African American; American Indian; Alaska Native; Asian; Native Hawaiian; Pacific Islander	Family income	Estimates are produced for the nation and non-overlapping geographic areas consisting of the 50 states, the District of Columbia, and selected large urban areas	Began data collection in April 1994 to monitor childhood immunization coverage—present	Datasets and related documentation available at <a href="http://www.cdc.gov/nchs/nis/datasets.htm">http://www.cdc.gov/nchs/nis/datasets.htm</a>	Publications available at <a href="http://www.cdc.gov/nchs/nis/reports.htm">http://www.cdc.gov/nchs/nis/reports.htm</a>

<sup>14</sup> Vaccinations included in the survey are: diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP); poliovirus vaccine (polio); measles-containing vaccine (MCV); Haemophilus influenzae type b vaccine (Hib); hepatitis B vaccine (Hep B); varicella zoster vaccine, pneumococcal conjugate vaccine (PCV), hepatitis A vaccine (Hep A) and influenza vaccine (FLU).

**Data Source: National Notifiable Diseases Surveillance System (<http://wwwn.cdc.gov/nndss/>)**

**Brief Description:** CDC’s National Notifiable Diseases Surveillance System (NNDSS) is a multifaceted public health disease surveillance system that gives public health officials powerful capabilities to monitor the occurrence and spread of diseases. Facets of NNDSS are used by numerous state, territorial, tribal and local health departments, and by partner organizations such as the Council of State and Territorial Epidemiologists.

**Examination Components:** State epidemiologists report cases of notifiable diseases to CDC, which tabulates these data weekly and in annual summaries. Data include the incidence of reportable diseases using uniform case definitions.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	–	–	–	Notifiable disease reports are received from health departments in the 50 states, 5 territories, New York City and the District of Columbia	1912-present	Downloadable resources available at <a href="http://wwwn.cdc.gov/nndss/downloads.html">http://wwwn.cdc.gov/nndss/downloads.html</a>	Tabulates and publishes these data in Morbidity and Mortality Weekly Report (MMWR) and in Summary of Notifiable Diseases

**Data Source:** National Nursing Assistant Survey (<http://www.cdc.gov/nchs/nnas.htm>)

**Brief Description:** The National Nursing Assistant Survey (NNAS) is the first national study of nursing assistants working in nursing facilities in the United States.

**Examination Components:** Survey of nursing assistants.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
4,542 nursing assistants	Young adults (18 years to 24); adults (25 years to 64); and older adults (65 years and older)	Hispanic; White; African American or Black; American Indian or Alaska Native; Asian; Native Hawaiian or Pacific Islander; Other	Gross income before taxes; employment; education; full/part-time employment	Metropolitan status	2004-2005	Data files available at <a href="http://www.cdc.gov/nchs/nnhs/nhs_questionnaires.htm">http://www.cdc.gov/nchs/nnhs/nhs_questionnaires.htm</a>	Nursing assistant tables 2004-2005 available at <a href="http://www.cdc.gov/nchs/nnhs/nursing_assistant_tables.htm">http://www.cdc.gov/nchs/nnhs/nursing_assistant_tables.htm</a>

**Data Source: National Outbreak Reporting System (<http://www.cdc.gov/nors/about.html>)**

**Brief Description:** CDC’s National Outbreak Response Team (NORS) collaborates with the national network of epidemiologists and other public health officials who investigate outbreaks of foodborne, waterborne, and other enteric illnesses in the United States. It works in partnership with U.S. state and local health departments, the U.S. Department of Agriculture, the Food and Drug Administration and PulseNet (a national surveillance network made up of state and local public health laboratories and federal food regulatory agency laboratories that perform pulsed-field gel electrophoresis on bacteria that may be foodborne). The Outbreak Response Team works to ensure rapid, coordinated detection and response to multistate outbreaks of enteric diseases and to promote comprehensive outbreak surveillance. It also seeks to improve collaboration and partnership among officials in local, state and federal agencies who work with foodborne and diarrheal disease outbreak surveillance and response.

In 2012, NORS monitored between 16 and 57 potential food poisoning clusters each week and investigated more than 200 multistate clusters. These investigations led to the identification of contaminated sources, which resulted in actions to stop the outbreaks. These actions, which kept further illnesses from happening, included the recalls of more than 300 products (e.g., peanut butter, leafy greens, cantaloupes, sprouts, ground beef, raw scraped ground tuna, and ricotta salata cheese). The first stage of survey administration is conducted using telephone interviews with households having age-eligible children. In the second stage, provider reports of vaccination information from the child’s medical record are obtained.

**Examination Components:** NORS is a web-based platform into which health departments enter outbreak information. It is designed to support reporting to CDC by local, state and territorial health departments in the U.S. of all waterborne disease and enteric disease outbreaks transmitted by food, contact with environmental sources, infected persons or animals or unknown modes of transmission. Through NORS, CDC collects reports of enteric disease outbreaks caused by bacterial, viral, parasitic, chemical, toxin and unknown agents, as well as waterborne outbreaks of nonenteric disease.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. disease outbreaks	–	–	–	CDC, by state and territorial public health agencies	2009-present	Available at <a href="http://www.cdc.gov/nors/data.html">http://www.cdc.gov/nors/data.html</a>	Publications and reports available at <a href="http://www.cdc.gov/nors/publications.html">http://www.cdc.gov/nors/publications.html</a> Other resources available at <a href="http://www.cdc.gov/nors/resources.html">http://www.cdc.gov/nors/resources.html</a>

**Data Source: National Program of Cancer Registries** ([http://www.cdc.gov/cancer/npcr/data\\_access/](http://www.cdc.gov/cancer/npcr/data_access/))

**Brief Description:** The National Program of Cancer Registries (NPCR) provides funds and guidance to states and United States territories to implement and enhance their cancer registries. As of 2010, NPCR supported central registries and promoted the use of registry data in 45 states, the District of Columbia, Puerto Rico and the Pacific Island jurisdictions.

**Examination Components:** Cancer registry data collected through NPCR are used to identify and monitor trends in cancer incidence and mortality; guide planning and evaluation of cancer control programs; help allocate health resources; contribute to clinical, epidemiologic and health services research; and respond to concerns from citizens over the presence of cancer in their communities.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All ages	White; Black/African American; American Indian; Alaska Native; Asian; Native Hawaiian; Pacific Islander	Varies depending on state; common variables include: education, income, health insurance	State	Since 1994	Must request access to dataset. Additional information available at <a href="http://www.cdc.gov/cancer/npcr/data_access/index.htm">http://www.cdc.gov/cancer/npcr/data_access/index.htm</a>	Yes Cancer data an statistical tools available at <a href="http://www.cdc.gov/cancer/npcr/tools.htm">http://www.cdc.gov/cancer/npcr/tools.htm</a>

**Data Source: National Study of Long-Term Care Providers (<http://www.cdc.gov/nchs/nsltcp.htm>)**

**Brief Description:** The biennial National Study of Long-Term Care Providers (NSLTCP) is a groundbreaking initiative to monitor trends in the major sectors of paid, regulated long-term care services providers. NSLTCP uses data from surveys of residential care communities and adult day services centers, and administrative data on home health agencies, nursing homes and hospices. The vision for NSLTCP is to offer reliable, accurate, relevant and timely statistical information to support and inform long-term care services policy, research and practice.

**Examination Components:** NSLTCP comprises two components: (1) primary data collected by the National Center for Health Statistics (NCHS) through surveys of residential care communities and adult day services centers; and (2) administrative data on nursing homes, home health agencies and hospices obtained from CMS.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
7,840 eligible residential care communities and 4,778 eligible adult day services centers were sampled	Older adults	Hispanic or Latino of any race; American Indian or Alaska Native (not Hispanic or Latino); Asian (not Hispanic or Latino); Black (not Hispanic or Latino); Native Hawaiian or Other Pacific Islander (not Hispanic or Latino); White (not Hispanic or Latino); Two or More Races (not Hispanic or Latino); Other	–	State	Since 2012	Datasets are available at Research Data Center locations at <a href="http://www.cdc.gov/nchs/nsltcp/nsltcp_questionnaires.htm">http://www.cdc.gov/nchs/nsltcp/nsltcp_questionnaires.htm</a>  Research Data Center website: <a href="http://www.cdc.gov/rdc/">http://www.cdc.gov/rdc/</a>	NSLTCP report in 2013 can be found at <a href="http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf">http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf</a>

**Data Source: National Survey of Adoptive Parents (<http://www.cdc.gov/nchs/slait/nsap.htm>)**

**Brief Description:** The National Survey of Adoptive Parents (NSAP) is the first large, nationally representative survey of adoptive families across adoption types .A secondary sample focuses on adopted children with special health care needs.The NSAP is conducted by CDC and is sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration for Children & Families (ACF).

**Examination Components:** Health and well-being of adopted children in the United States.; information about their family’s well-being and adoption-related experiences, including parents’ reasons for adoption and decisions about adoption type, adoption preparation, openness, and post-adoption financial and nonfinancial service utilization.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adopted children in the U.S. ages 0-17, excluding step-parent adoptions; a second sample titled the National Survey of Adoptive Parents of Children with Special Health Care Needs (NSAP-SN) is nationally representative of adopted children with special health care needs (data collected from parents)	Parents who have adopted a child 0 to 17 years old	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other.	Adoption eligibility screening and demographic characteristics, parent and child well-being; adoption agreement and post adoption financial services; post adoption nonfinancial support.	National	2007-2008	Available publicly at: <a href="http://www.cdc.gov/nchs/slait/nsap.htm">http://www.cdc.gov/nchs/slait/nsap.htm</a>	A one-time report is available at: <a href="http://aspe.hhs.gov/hsp/09/NSAP/chartbook/index.cfm">http://aspe.hhs.gov/hsp/09/NSAP/chartbook/index.cfm</a>

**Data Source: National Survey of Family Growth (<http://www.cdc.gov/nchs/nsfg.htm>)**

**Brief Description:** The National Survey of Family Growth (NSFG) gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men’s and women’s health. The survey results are used by HHS and others to plan health services and health education programs, and to do statistical studies of families, fertility and health.

**Examination Components:** Personal interviews.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
5,000 men and women; oversample Blacks, Hispanics, and teens	15-44 years	American Indian or Alaska Native; Asian; Native Hawaiian or Other Pacific Islander; Black or African American; White; Hispanic Groups: Puerto Rican, Cuban, Mexican, Central or South American, member of some other group	Family and individual income; sources of income; education <sup>15</sup>	National	1973-2002: periodically conducted; 2006-present: conducted nearly continuously (2006-2010; 2011-2015)	Public Use Files, usable without restrictions: <a href="http://www.cdc.gov/nchs/nsfg/nsfg_products.htm">http://www.cdc.gov/nchs/nsfg/nsfg_products.htm</a>  Key statistics available at <a href="http://www.cdc.gov/nchs/nsfg/key_statistics.htm">http://www.cdc.gov/nchs/nsfg/key_statistics.htm</a>	Publications and reports available at <a href="http://www.cdc.gov/nchs/nsfg/nsfg_products.htm">http://www.cdc.gov/nchs/nsfg/nsfg_products.htm</a>

<sup>15</sup> Other information: primary language information collected starting fall 2011; contraception and sterilization; teenage sexual activity and pregnancy; family planning/unintended pregnancy; infertility, adoption, breastfeeding; marriage, divorce, and cohabitation; fatherhood involvement; HIV risk behavior.

**Data Source: National Survey of Residential Care Facilities** (<http://www.cdc.gov/nchs/nsrcf.htm>)

**Brief Description:** The National Survey of Residential Care Facilities (NSRCF) is a first-time national data collection effort to gather information about the characteristics of residential care facilities, including assisted living residences, board and care homes, congregate care, enriched housing programs, homes for the aged, personal care homes and shared housing establishments.

**Examination Components:** 2010 NSRCF data were collected through in-person interviews with facility directors and their designated staffs; no interviews were conducted directly with residents. During the interviews, information was collected on: 1) facility characteristics, such as physical structure and environment, types of services offered, types of staff employed and policies on admission, retention and discharge; and 2) resident characteristics, such as demographics, involvement in inside and outside activities, use of services, charges for care, health status, and cognitive and physical functioning.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
8,450 residents; 2,500 facilities	Adults (25 years to 64): and older adults (65 years and older)	Hispanic/Latino/ Spanish Origin or Descent; White or Caucasian; Black or African American; Asian; Hawaiian or Pacific Islander; American Indian or Alaska Native	Health status and functioning; facility characteristics; facility structure/ environment; staffing; practice; services; charges; use of electronic medical records	National	2010 (one-time survey)	Yes; Public Use Files available at: <a href="http://www.cdc.gov/nchs/nsrcf/nsrcf_questionnaires.htm">http://www.cdc.gov/nchs/nsrcf/nsrcf_questionnaires.htm</a>	Yes; summary statistics; 2012-2013  Publications and products available at <a href="http://www.cdc.gov/nchs/nsrcf/nsrcf_products.htm">http://www.cdc.gov/nchs/nsrcf/nsrcf_products.htm</a>

**Data Source: National Violent Death Reporting System** (<http://www.cdc.gov/violenceprevention/nvdrs/>)

**Brief Description:** The National Violent Death Reporting System (NVDRS) can help provide states and communities with a clearer understanding of violent deaths so they can be prevented. More than 38,000 people died by suicide in the United States in 2010. Homicide claimed another 16,000 people. CDC is committed to preventing and lowering the number of violent deaths in the U.S.

**Examination Components:** To inform decision makers and program planners about the magnitude, trends and characteristics of violent deaths in their state or community so appropriate prevention efforts can be identified and implemented; to facilitate the evaluation of state-based prevention programs and strategies. Information includes child maltreatment or child abuse fatalities, intimate partner homicides, other homicides, suicides, deaths where individuals are killed by law enforcement in the line of duty, unintentional firearm injury deaths and deaths of undetermined intent.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Violent deaths in the U.S.	All ages	All races/ethnicities	Cost of injury	States, county (surveillance from 32 states)	2002-present	Data inquiry available from WISQARS (starting in 2004)—a web-based injury statistics query—at <a href="http://www.cdc.gov/injury/wisqars/index.html">http://www.cdc.gov/injury/wisqars/index.html</a>	Reports available at <a href="http://www.cdc.gov/injury/wisqars/nvdrs.html">http://www.cdc.gov/injury/wisqars/nvdrs.html</a>

**Data Source: National Vital Statistics System (<http://www.cdc.gov/nchs/nvss.htm>)**

**Brief Description:** The National Vital Statistics System (NVSS) provides the nation’s official vital statistics data based on the collection and registration of birth and death events at the state and local levels. The National Center for Health Statistics (NCHS) works in partnership with vital registration systems in each jurisdiction to produce critical information on such topics as teenage births and birth rates, prenatal care and birth weight, risk factors for adverse pregnancy outcomes, infant mortality rates, leading causes of death and life expectancy. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces and fetal deaths.

**Examination Components:** This an intergovernmental system of sharing data on the vital statistics of the population of the United States. It involves coordination between the different state health departments of the U.S. states and NCHS, a division of CDC.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All births (about 4 million, annually); all deaths (about 2.5 million, annually); reported fetal deaths of 20+ weeks gestation; counts of marriages and divorces	N/A	Office of Management and Budget (OMB) race categories and five Hispanic groups (additional race and Hispanic detail available for some states); multiple race information available for selected states	Source of payment for delivery for some states; education <sup>16</sup>	These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events – births, deaths, marriages, divorces and fetal deaths. Vital statistics data are also available online. In the U.S., legal authority for the registration of these events resides individually with the 50 states, 2 cities (Washington, DC, and New York City) and 5 territories (Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands).	Annual	Available publicly at: <a href="http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm">http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm</a>	Yes, Vital statistics available online at <a href="http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm">http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm</a>

<sup>16</sup> Other information includes: births, deaths, and fetal deaths; marital status; birth and death rates; birthweight; teen and nonmarital births; pregnancy outcomes; method of delivery; multiple births; infant mortality; life expectancy.

**Data Source:** National Youth Fitness Survey (<http://www.cdc.gov/nchs/nyyfs.htm>)

**Brief Description:** The 2012 NHANES National Youth Fitness Survey (NNYFS) collected data on exercise and the dietary habits of United States children ages 3 to 15 through interviews and fitness tests conducted in state-of-the-art mobile centers which cross the country. The fitness tests included standardized measurements of core upper and lower body muscle strength as well as a measurement of cardiovascular fitness by walking and running on a treadmill.

**Examination Components:** Personal interviews, physical examinations, and dietary assessment.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children	3-15 years of age	Black; White; Hispanic Origin; Other	Income and poverty status; education <sup>17</sup>	National estimates	N/A	Yes; datasets and related documentation available at <a href="http://wwwn.cdc.gov/nchs/nhane/s/search/nyyfs12.aspx">http://wwwn.cdc.gov/nchs/nhane/s/search/nyyfs12.aspx</a>	2012 report available at <a href="http://www.cdc.gov/nchs/data/series/sr_02/sr02_163.pdf">http://www.cdc.gov/nchs/data/series/sr_02/sr02_163.pdf</a>

<sup>17</sup> Other information provided: birthplace; acculturation questions regarding language usually spoken at home; physical activity and sedentary behaviors; dietary intake and diet behavior; dietary supplements and prescription medications; overweight and diabetes; respiratory diseases.

**Data Source: National Youth Tobacco Survey** ([http://www.cdc.gov/tobacco/data\\_statistics/surveys/nyts/](http://www.cdc.gov/tobacco/data_statistics/surveys/nyts/))

**Brief Description:** The National Youth Tobacco Survey (NYTS) was designed to provide national data on long-term, intermediate and short-term indicators key to the design, implementation and evaluation of comprehensive tobacco prevention and control programs. The NYTS also serves as a baseline for comparing progress toward meeting selected Healthy People 2020 goals for reducing tobacco use among youth:

TU-18.1—adolescent in grades 6–12 exposed to tobacco advertisement and promotions on the Internet

TU-18.2—adolescent in grades 6–12 exposed to tobacco advertisement and promotions in magazines and newspapers

**Examination Components:** Items measured as part of the NYTS survey include correlates of tobacco use such as demographics, minors’ access to tobacco and exposure to secondhand smoke.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. students in grades 6 through 12	11-18 years	American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White Ethnicity: Mexican; Mexican American, or Chicano; Puerto Rican; Cuban or Cuban American; Hispanic or Latino	Money to spend each week	National, State	2000-present	NYTS datasets are available for public use so that researchers and public health managers can explore the data in detail. In addition, states can compare their estimates of prevalence of youth tobacco use with national data.	Data and statistics and key reports available at <a href="http://www.cdc.gov/tobacco/data_statistics/index.htm">http://www.cdc.gov/tobacco/data_statistics/index.htm</a>

**Data Source: Perinatal Hepatitis B Prevention Program** (<http://www.cdc.gov/hepatitis/partners/PeriHepBCoord.htm>)

**Brief Description:** CDC's funded state, local and territorial programs that focus on preventing Hepatitis B virus transmission from pregnant women to their newborns.

**Examination Components:** The number of HBsAg-positive pregnant women identified and number of these women who are case managed, the number of infants born to HBsAg-positive pregnant women identified and the number who are case managed, the number and proportion of infants born to HBsAg-positive mothers receiving post-exposure immunoprophylaxis at birth, completion of the vaccination series by 8 and 12 months of age, completing post-vaccination serologic testing for HBsAg and for anti-HBs with a result known before 24 months of age, and the number of infants lost to follow-up.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Infants born to women with hepatitis B infection during pregnancy (includes both acute and chronic hepatitis B infection)	Women of reproductive age and newborns	All race and ethnicities	–	State, local, territorial	–	Viral hepatitis statistics and surveillance available at <a href="http://www.cdc.gov/hepatitis/statistics/index.htm">http://www.cdc.gov/hepatitis/statistics/index.htm</a>	Information resources on state programs available at <a href="http://www.cdc.gov/hepatitis/partners/perinatal/perihepbprogramsites.htm">http://www.cdc.gov/hepatitis/partners/perinatal/perihepbprogramsites.htm</a> Additional information including the National Quality Forum (NQF) endorsement of CDC NQF Perinatal Measure 0475 “Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge, available at <a href="http://www.cdc.gov/hepatitis/partners/perihepbcoord.htm">http://www.cdc.gov/hepatitis/partners/perihepbcoord.htm</a>

**Data Source:** Chronic Disease State Policy Tracking System (<http://nccd.cdc.gov/CDPHPPolicySearch//Default.aspx>)

**Brief Description:** Recognizing the unique role that states play in promoting health and preventing disease, CDC monitors state legislative and regulatory actions that support healthy eating and active living. This data is housed and maintained by CDC in the online database of State Legislative and Regulatory Action (SLRA) to Prevent Obesity and Improve Nutrition and Physical Activity.

**Examination Components:** The SLRA is available to public health practitioners, opinion leaders, policymakers and researchers in the field, and it provides access to information on state legislation that supports obesity prevention and organizes this information based on unique searchable metadata (e.g., state, setting, year, policy topic, and health category).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
This system contains over 6,000 policies related to chronic disease prevention and health promotion.	–	–	–	State	Data available starting 1979	Policies can be browsed, or specific characteristics (e.g., health category, setting, status) can be selected to generate information by state .Available at <a href="http://nccd.cdc.gov/CDPHPPolicySearch/Default.aspx">http://nccd.cdc.gov/CDPHPPolicySearch/Default.aspx</a>	The data including policies are made available solely for the purpose of public health information, research, and surveillance.

**Data Source: Pregnancy Risk Assessment Monitoring System (<http://www.cdc.gov/prams/>)**

**Brief Description:** The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the CDC and state health departments. It collects state-specific, population-based data on maternal attitudes and experiences before, during and shortly after pregnancy.

**Examination Components:** PRAMS provides data for state health officials to use in order to improve the health of mothers and infants. It allows CDC and the states to monitor changes in maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, infant health).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Pregnant and parenting women	Women of reproductive age	All races/ethnicities	Insurance	PRAMS not only provides state-specific data, but also allows comparisons among participating states because the same data collection methods are used in all states.	Data availability starts in 1988. PRAMS has a minimum overall response rate threshold policy for the release of data. For years 2006 and earlier, this threshold was 70%. Beginning in 2007, the threshold changed to 65%. For any given year, the majority, but not all states meet the threshold. For this reason the number of states with data available may vary from year to year.	Yes, but researchers may request data files for studies that involve multiple states by submitting a proposal to CDC. The information on the submission process is available at <a href="http://www.cdc.gov/prams/researchers.htm">http://www.cdc.gov/prams/researchers.htm</a> PRAMS Data Portal offer online search and data retrieval starting with 2000 data, available at <a href="http://www.cdc.gov/prams/work-directly-pramstat.html">http://www.cdc.gov/prams/work-directly-pramstat.html</a>	Reports are available at <a href="http://www.cdc.gov/prams/pramsreport.html">http://www.cdc.gov/prams/pramsreport.html</a>

**Data Source:** School Health Policies and Practices Study (<http://www.cdc.gov/HealthyYouth/shpps/index.htm>)

**Brief Description:** The School Health Policies and Practices Study (SHPPS) is a national survey periodically conducted to assess school health policies and practices at the state, district, school and classroom levels.

**Examination Components:** Components assessed include health education, physical education and activity, health services, mental health and social services, nutrition services, healthy and safe school environment, faculty and staff health promotion, and family and community involvement.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
State education agencies and public school districts	–	–	–	Conducted at the state, district, school and classroom levels nationwide	SHPPS was conducted in 1994, 2000, and 2006, and state- and district-level data collection for the 2012 study is underway. School- and classroom-level data collection will take place in 2014.	Data files and documentation, including codebooks and questionnaires, are available for three years: 1994, 2000, and 2006. For each year, data and documentation are available by component (Health Education, Physical Education and Activity, Health Services, Mental Health and Social Services, Nutrition Services, Safe and Healthy School Environment, and Faculty and Staff Health Promotion), as well as level (state, district, school, and classroom)  A data request form is available at <a href="http://www.cdc.gov/healthyouth/data/shpps/contact.htm">http://www.cdc.gov/healthyouth/data/shpps/contact.htm</a>	<a href="http://www.cdc.gov/HealthyYouth/shpps/index.htm">http://www.cdc.gov/HealthyYouth/shpps/index.htm</a>

**Data Source: School Health Profiles** (<http://www.cdc.gov/healthyyouth/profiles/>)

**Brief Description:** The School Health Profiles (Profiles) is a system of surveys assessing school health policies and practices in states, large urban school districts, territories and tribal governments.

**Examination Components:** Profiles surveys are conducted every two years by education and health agencies among middle and high school principals and health education teachers. Profiles monitor the status of school health education requirements and content, physical education requirements, school health policies related to HIV/AIDS, tobacco use prevention, nutrition, asthma management activities, and family and community involvement in school health programs.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Secondary schools in a state, large urban school district, territory or tribal government	–	–	–	States, districts, territories, tribal government	Reports available starting in 2010	<p>Profiles reports from surveys conducted since 1996, as well as item rationales for previous versions of Profiles questionnaires are available upon request.</p> <p>Form is available at <a href="http://www.cdc.gov/healthyouth/data/profiles/contact.htm">http://www.cdc.gov/healthyouth/data/profiles/contact.htm</a></p>	2014 and previous School Health Profiles available at <a href="http://www.cdc.gov/healthyouth/data/profiles/pdf/2014/2014_profiles_report.pdf">http://www.cdc.gov/healthyouth/data/profiles/pdf/2014/2014_profiles_report.pdf</a>

**Data Source: Sexually Transmitted Diseases Surveillance System** (<http://www.cdc.gov/STD/> and <http://www.cdc.gov/std/stats/e>)

**Brief Description:** Sexually Transmitted Diseases STD Surveillance System (STDSS) information on the incidence and prevalence of STDs is used to inform public and private health efforts to control these diseases. Case reporting data are available for nationally notifiable chancroid, chlamydia, gonorrhea and syphilis. Surveillance of other STDs, such as genital herpes, simplex virus, genital warts, or other human papillomavirus infections and trichomoniasis are based on estimates of visits to physicians’ office practices provided by the National Disease and Therapeutic Index.

**Examination Components:** Case reports of STDs are reported to CDC by STD surveillance systems operated by state and local STD control programs and state and local health departments.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Case of STDs reported to CDC in the U.S., DC, and territories	–		–	Coverage includes the 50 states, the District of Columbia and U.S. dependencies, possessions, and independent nations in free association with the U.S.	1941-present	Data can be searched and extracted from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas available at <a href="http://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=bb-od-atlas_005">http://www.cdc.gov/nchhstp/atlas/index.htm?s_cid=bb-od-atlas_005</a>	2014 Report available at <a href="http://www.cdc.gov/std/stats14/default.htm">http://www.cdc.gov/std/stats14/default.htm</a>

**Data Source:** State and Local Area Integrated Telephone Survey (<http://www.cdc.gov/nchs/slait.htm>)

**Brief Description:** The State and Local Area Integrated Telephone Survey draws on the sampling frame of the National Immunization Survey (NIS) to enable cost-effective surveys of children’s health at the state level or national follow-up surveys of specific subpopulations (including adopted children, children with autism, developmental delay or intellectual disability, children in nonparental care and children with ADHD or Tourette Syndrome). Survey modules include National Survey of Adoptive Parents 2007; National Survey of Adoptive Parents of Children with Special Health Care Needs 2008; National Survey of Children in Nonparental Care 2013; National Survey of Children with Special Health Care Needs 2001, 2005-06, 2009-10; National Survey of Children’s Health 2003, 2007, 2011; National Survey of Diagnosis and Treatment of ADHD and Tourette Syndrome 2014; Survey of Pathways to Diagnosis and Services 2011.

**Examination Components:** Telephone interview, using sampling frame from the NIS.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Module-specific: all children; children with special health care needs; adopted children; children in nonparental care; or children with certain health conditions	Children	All races/ethnicities	Income and poverty levels; education; insurance coverage; primary language; demographic characteristics; family resources data; health care utilization; functioning; unmet needs; medical home	Module-specific: for National Survey of Children with Special Healthcare Needs and National Survey of Children’s Health, state is identified in public files, and estimates are representative at the state level (other modules are national)	Periodic and module-specific	Datasets are available for public download.	Periodic reports and publications are available at: <a href="http://www.cdc.gov/nchs/slait/slait_products.htm">http://www.cdc.gov/nchs/slait/slait_products.htm</a>

**Data Source:** State Tobacco Activities Tracking and Evaluation (STATE) System (<http://www.cdc.gov/STATESystem/>)

**Brief Description:** The State Tobacco Activities Tracking and Evaluation (STATE) System is an interactive application that houses and displays current and historical state-level data on tobacco use prevention and control.

**Examination Components:** The STATE System includes data on cigarette and other tobacco use, resident population estimates, tobacco manufacturing and sales, health consequences and cost, and state tobacco-control legislation.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults and youth	Adults and youth	All races/ethnicities	Varies according to State	States	1996-present	<p>A tobacco use data portal is available at <a href="https://chronicdata.cdc.gov/health-area/tobacco-use">https://chronicdata.cdc.gov/health-area/tobacco-use</a></p> <p>State highlights available at <a href="http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_STATE.Highlights&amp;isLocation=US&amp;rdDashboardTabs=HLR_QUI&amp;rdRequestForwarding=Form">http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_STATE.Highlights&amp;isLocation=US&amp;rdDashboardTabs=HLR_QUI&amp;rdRequestForwarding=Form</a></p>	<p>Customized reports available at <a href="http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_State.CustomReports">http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_State.CustomReports</a></p>

**Data Source: Universal Data Collection System** ([http://www.2a.cdc.gov/ncbddd/htcweb/UDC\\_Report/UDC\\_Report.asp#public](http://www.2a.cdc.gov/ncbddd/htcweb/UDC_Report/UDC_Report.asp#public))

**Brief Description:** One of the major challenges facing scientists who work on rare disorders, such as hemophilia, is lack of uniform health data. To address this issue and to advance health research, CDC created a national public health surveillance project called the Universal Data Collection (UDC) system. UDC is carried out with the help of federally funded hemophilia treatment centers (HTCs) in the United States and its territories.

**Examination Components:** UDC system collects data from people with hemophilia and other bleeding disorders of all ages to better understand issues across the lifespan. The type of health information that is collected includes: diagnosis; bleeding history; use of treatment products; ability to attend school or work; overall activity level; joint range of motion of the hips, knees, shoulders, elbows, and ankles; blood samples to check for viruses; and quality-of-life information.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients with bleeding disorders	Ages 2 through 65+	White; Black; Hispanic; Asian/Pacific Islander; American Indian/Alaska Native; Other	Education; health insurance	–	1998-2011	Only in aggregate	UDC data and reports are available to HTC staff; national and regional reports available to the public

**Data Source: Vaccine Adverse Event Reporting System (<https://vaers.hhs.gov/data/data>)**

**Brief Description:** The Vaccine Adverse Event Reporting System (VAERS) is a national vaccine safety surveillance program co-sponsored by CDC and FDA. VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of vaccines licensed for use in the United States. VAERS provides a nationwide mechanism by which adverse events following immunization may be reported, analyzed and made available to the public. VAERS also provides a vehicle for disseminating vaccine safety-related information to parents and guardians, health care providers, vaccine manufacturers, state vaccine programs and other constituencies.

**Examination Components:** This reporting system examines vaccines, symptoms, doses, dates, places and more.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Anyone who has experienced a clinically significant medical event that occurs after the administration of any vaccine licensed in the U.S.	All ages (measured by years and months)	–	–	State	1990-present	Available for anyone to search or download at <a href="https://vaers.hhs.gov/data/index">https://vaers.hhs.gov/data/index</a>	<a href="https://vaers.hhs.gov/resources/vaersmaterialspublications">https://vaers.hhs.gov/resources/vaersmaterialspublications</a>  Information on State and Territorial Immunization Programs available at <a href="https://vaers.hhs.gov/coordinators/index">https://vaers.hhs.gov/coordinators/index</a>

**Data Source: Vaccine Safety Datalink Project** (<http://www.cdc.gov/vaccinesafety/Activities/vsd/accessing-data.html>)

**Brief Description:** The Vaccine Safety Datalink (VSD) is a collaborative project between CDC’s Immunization Safety Office and nine health care organizations. The VSD started in 1990 and continues today in order to monitor safety of vaccines and conduct studies about rare and serious adverse events following immunization.

**Examination Components:** The VSD uses electronic health data from each participating site; this includes information on vaccines – the kind of vaccine that is given to each patient, date of vaccination and other vaccinations given on the same day. The VSD also uses information on medical illnesses that have been diagnosed at doctors’ offices and during urgent care visits, emergency department visits and hospital stays. The VSD conducts vaccine safety studies based on questions or concerns raised from the medical literature and reports to the Vaccine Adverse Event Reporting System (VAERS) .When there are new vaccines that have been recommended for use in the United States, or if there are changes in how a vaccine is recommended, the VSD will monitor the safety of these vaccines.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Infants and children receiving care at nine nationwide health care organizations	Ages 0-10, longitudinally	–	–	Health care organization (one of nine, nationwide)	1994-1999	Yes, upon request at <a href="http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/accessing-data.html">http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/accessing-data.html</a>	Information for health care providers available at <a href="http://www.cdc.gov/vaccinesafety/hcproviders/index.html">http://www.cdc.gov/vaccinesafety/hcproviders/index.html</a>  Information for parents and caregivers <a href="http://www.cdc.gov/vaccinesafety/caregivers/index.html">http://www.cdc.gov/vaccinesafety/caregivers/index.html</a>

**Data Source: Wide-ranging Online Data for Epidemiologic Research (WONDER) (<http://wonder.cdc.gov/>)**

**Brief Description:** The CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) is a web application that makes many health-related data sets available to the worldwide public health community. Users include state and local health departments, academic researchers, health care providers, CDC surveillance programs and the general public. The data found on CDC WONDER aid users in public health research, decision-making, priority setting, program evaluation and resource allocation.

**Examination Components:** CDC WONDER manages nearly 20 collections of public-use data for United States births, deaths, cancer diagnoses, Tuberculosis (TB) cases, vaccinations, environmental exposures and population estimates, among many other topics. These data collections are available as online databases and provide public access to ad-hoc queries, summary statistics, maps, charts and data extracts. Most of the data are updated annually; some collections are updated monthly or weekly. A comprehensive list of all datasets with brief description is available at <http://wonder.cdc.gov/DataSets.html>.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
–	–	–	–	–	–	<p>Yes, information can be retrieved by systems or by topic, and an alphabetical list is also provided at <a href="http://wonder.cdc.gov/Welcome.html">http://wonder.cdc.gov/Welcome.html</a></p> <p>Data user restrictions information available at <a href="http://wonder.cdc.gov/datauser.html">http://wonder.cdc.gov/datauser.html</a></p>	<p>Information on what is new in CDC WONDER is made available on a timely basis at <a href="http://wonder.cdc.gov/WhatsNew.html">http://wonder.cdc.gov/WhatsNew.html</a></p>

**Data Source:** Youth Risk Behavior Surveillance System (<http://www.cdc.gov/healthyyouth/data/yrbs/data.htm>)

**Brief Description:** The Youth Risk Behavior Surveillance System (YRBSS) monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults. YRBSS includes a national school-based survey conducted by CDC and state, territorial, tribal and local surveys conducted by state, territorial and local education and health agencies, and by tribal governments.

**Examination Components:** Indicators assessed include behaviors that contribute to unintentional injuries and violence; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Youth and young adults in grades 9-12 in the 50 states and the District of Columbia	12-18 years old	Hispanic/non-Hispanic; American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian/Pacific Islander; White	–	National, state, district, territory, tribe	The YRBSS data are provided every two years since 1991	Yes, data files can be downloaded from website	Published articles using the data are available at: <a href="http://www.cdc.gov/healthyyouth/data/yrbs/articles.htm">http://www.cdc.gov/healthyyouth/data/yrbs/articles.htm</a>



## Department of Health and Human Services Centers for Medicare & Medicaid Services



**Data Source:** CMS Research Data Assistance Center (<http://www.resdac.org>)

**Brief Description:** The Research Data Assistance Center (ResDAC), located at the University of Minnesota and staffed by masters-level, trained technical advisors, provides technical assistance to researchers interested in using Medicare and/or Medicaid data.

ResDAC assists with the following Medicare- and Medicaid-related data tasks:

- Understanding and interpreting Medicare and Medicaid program policies and coverage
- Learning about the strengths, weaknesses and applications of Medicare and Medicaid data
- Understanding the creation of CMS's administrative data files and claims processing
- Reviewing the methods of cohort identification and file specifications
- Generating cost estimates and invoices for CMS data
- Preparing a request for CMS data

**Examination Components:** CMS has an infrastructure in place (ResDAC) that provides comprehensive descriptions of each of the types of files available, categorized as Research Identifiable Files, Limited Data Sets and Public Use Files. ResDAC assists users in their efforts to identify, obtain and utilize CMS data for specific research projects. The Chronic Conditions Warehouse (CCW) is a tool for accessing and/or receiving data, not a dataset per se. A user's point of entry to the CCW environment begins with ResDAC through the link at <http://www.resdac.org/cms-data/file-directory>.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Medicare and Medicaid populations	Older adults $\geq$ 65 years. People < 65 years with certain disabilities. People of all ages with end stage renal disease.	Black or African American, White, Hispanic or Latino (of any race), Native American, Asian or Pacific Islander, Two or More, Missing or Unable to Determine	Insurance coverage, Socio demographics	National, State	Starting 1999 for Medicare and Medicaid data	Yes; Public Use Files, Virtual Research Data Center, Limited Datasets, Research Identifiable Files	Information on Medicare and Medicaid milestones available at <a href="https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf">https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf</a>

**Data Source: Medicare – Clinical Performance Measures Project** (<http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html>)

**Brief Description:** The Medicare – Clinical Performance Measures (CPM) project was initiated to develop measures to track the quality of renal dialysis services provided under the Medicare program. Twenty-six measures were developed by experts in the end-stage renal disease field, tested for reliability and validity, and adopted by CMS in 2008.

**Examination Components:** Clinical Performance Measures developed by CMS.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with renal disease who require dialysis services	All ages	All races/ethnicities	Medicare population by age, race, gender, coverage type, Medicare status, Fee-for-Service status	State	2008-present	Yes	Summary reports available at: <a href="http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html">http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html</a>

**Data Source: Medicare – Hospital Compare** (<http://data.medicare.gov/data/hospital-compare>)

**Brief Description:** Hospital Compare is a consumer-oriented database that provides information on how well hospitals provide recommended care to their patients. This information can help consumers make informed decisions about health care.

**Examination Components:** Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery and other conditions. CMS compiles information from claims and enrollment data for patients in fee-for-services Medicare. It does not include people in Medicare Advantage plans or people who do not have Medicare. It also displays Medicare inpatient hospital payment information and Medicare patients treated (volume) for certain illnesses or diagnoses.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Medicare fee-for-services population	Medicare - Adults 64 years and younger, 65 to 74 years, 75 to 84 years, and 85 years and older	All races/ethnicities	Data aggregated by hospital. All US adults, with exception of the 30-day risk adjusted death and remission measures that only include Medicare beneficiaries hospitalized for heart attack and pneumonia.	National, State	2010-present	Yes	Yes; Hospital compare displays the Survey of Patients' Hospital Experiences, using data collected from the Hospital Consumer Assessment Providers and Systems (HCAHPS) Survey. The intent is to provide standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care.

**Data Source:** CMS Data Navigator, CMS Research, Statistics, Data & Systems (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems.html>)

**Brief Description:** CMS Data Navigator application is an easy-to-use, menu-driven search tool that makes the data and information resources of the CMS more easily available. Use the Data Navigator to find data and information products for specific CMS programs, such as Medicare and Medicaid, or on specific health care topics or settings-of-care. Navigator displays search results by data type, making it easier to locate specific types of information (e.g., data files, publications, statistical reports, etc.).

**Examination Components:** Clinical Performance Measures developed by CMS.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Medicare and Medicaid populations	All ages	All races/ethnicities	The Data Navigator is used to find data and information products for specific CMS programs, such as Medicare and Medicaid, or on specific health care topics or settings-of-care.	National, State	–	Yes	The Navigator displays search results by data type making it easier to locate specific types of information such as data files, publications, statistical reports, and others.



## Department of Health and Human Services Health Resources and Services Administration



**Data Source:** AIDS Education and Training Centers (<http://hab.hrsa.gov/abouthab/parteducation.html>)

**Brief Description:** The AIDS Education and Training Centers (AETCs) program of the Ryan White HIV/AIDS Program supports a network of 11 regional centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.

Regional, local and national AETCs, and telehealth and graduate health profession programs provide case-based and organizational education, training, consulting and technical assistance. Regional centers and local sites work directly within the community through targeted training and by linking providers with local experts. National centers provide resources, assistance and training to support health care professionals and faculty in the AETC network and beyond .

**Examination Components:** AETCs submit to HRSA the standard AETC data collection instruments, such as the Participant Information Forms and the Event Record.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
<p>Training is targeted to providers who serve minority populations, the homeless, rural communities, incarcerated persons, and Ryan White HIV/AIDS Program–funded sites. AETCs focus on training primary health care clinicians (physicians, physician assistants, nurses, nurse practitioners, dentists, pharmacists); training activities are based on assessed local needs. Emphasis is placed on interactive, hands-on training and clinical consultation to assist providers with complex issues, including those related to the management of highly active antiretroviral therapy.</p>	–	–	–	Regional	Annually 2008-present	Yes	<p>Annual Reports/resources available at <a href="http://www.aidsetc.org/">http://www.aidsetc.org/</a> 2008-2009 AETC Report available at <a href="http://hab.hrsa.gov/about/hab/files/aetcreport200809.pdf">http://hab.hrsa.gov/about/hab/files/aetcreport200809.pdf</a></p>

**Data Source: Area Resource File (<http://arf.hrsa.gov/>)**

**Brief Description:** Bureau of Health Professions within HRSA houses the Area Resource File (ARF). The ARF is a dataset comprised of data collected from more than 50 sources and contains more than 6,000 variables related to health care access at the county level. ARF contains information on health professions, health facilities, hospitals, vital statistics, population and economics, utilization, expenditures and health professions training. The ARF also contains geographic codes and descriptors which enable it to be linked to other files and to put counties into various geographic groupings. All information contained on the ARF is derived from existing data sources.

**Examination Components:** The ARF is designed to be used by planners, policy makers, researchers and other professionals interested in the nation’s health care delivery system because of its county-specific health resource information system.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The basic county-specific Area Health Resource File (AHRF) is the nucleus of the overall AHRF system. It is a database containing more than 6,000 variables for each of the nation’s counties	Ages less than 5 to 84+ years	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Two or More Races	AHRF contains information on health facilities, health professions, and measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics.	The basic file contains geographic codes and descriptors which enable it to be linked to many other files and to aggregate counties into various geographic groupings.	Reporting periods are based on the availability of each data element. Effective with the 2001 release of the AHRF, all independent cities and Alaska boroughs/census areas are available for 1992 and later data.	The ARF is available in two versions – an ASCII version and a Microsoft Access version.	Maintained annually since the mid-1970s; the 2005 file primarily has data from 1980 to 2004, but some fields have information dating back to 1950; historical versions of the file can be purchased; the ARF is released annually.

**Data Source:** HIV/AIDS Bureau Ryan White HIV/AIDS Program Services Report (<http://hab.hrsa.gov/>)

**Brief Description:** This Program Services Report (PSR) is a client-level data report that provides data on the characteristics of the HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program grantees, their providers and the clients served with program funds. Reports cover the full calendar year.

**Examination Components:** The RSR has three components: 1) the Grantee Report: collects basic information about grantee organization and funded service provider contracts; 2) the Provider Report: collects basic information about service provider agency and services delivered under each Ryan White Program contract; and 3) the Client Report: contains client-level data for each client who received a Ryan White Program-funded service during the reporting period.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals living with HIV	Infants/toddlers, children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	Black or African American; White, Hispanic or Latino (of any race); Native American; Asian or Pacific Islander	Low income/poverty; housing; health coverage	State	Annual; 2010-present	Yes	Data are reported annually in the second quarter of the fiscal year. The Ryan White Services Report submission deadline is March 31 every year. Periodic reports and publications are available at: <a href="http://hab.hrsa.gov/newspublications/index.html">http://hab.hrsa.gov/newspublications/index.html</a>

**Data Source: National Survey of Children’s Health (<http://www.cdc.gov/nchs/slait/nsch.htm>)**

**Brief Description:** This survey, sponsored by the Maternal and Child Health Bureau (MCHB) of HRSA, examines the physical and emotional health of children ages 0-17 years of age. Special emphasis is placed on factors that may relate to well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods. Another purpose of this dataset is to provide baseline estimates for federal and state Title V Maternal and Child Health performance measures, MCHB companion objectives for Healthy People 2020, and data for each state’s five-year Title V needs assessment.

**Examination Components:** Emphasis is placed on factors that may relate to well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods. In the 2011-2012 survey, questions also asked about uninsured children from some households to assess their parents’ awareness of, experience with and interest in enrolling in Medicaid and the State Children’s Health Insurance Program (CHIP).

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children ages 0-17 years of age (data collected from parent or guardian)	Children 0 to 17 years old	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other; Don't Know; Refused	Demographics, early childhood-specific information; health insurance; free/reduced lunch; access to health services; substantive health and well-being data for the child and his/her family (including chronic diseases, family functioning, health status indicators; and parents' perceptions of neighborhood characteristics); poverty status; Temporary Assistance for Needy Families (TANF) participation; Supplemental Nutrition Assistance Program (SNAP) participation; WIC participation.	State	January 2003 to July of 2004; April 2007 to July 2008; February 2011 through June 2012	Yes	Periodically, available at: <a href="http://www.cdc.gov/nchs/slait/nsch.htm">http://www.cdc.gov/nchs/slait/nsch.htm</a>

**Data Source: National Survey of Children with Special Healthcare Needs** (<http://mchb.hrsa.gov/cshcn0910/>)

**Brief Description:** The National Survey of Children with Special Healthcare Needs (NS–CSHCN) explores the extent to which children with special health care needs (CSHCN) have medical homes, adequate health insurance, access to needed services and adequate care coordination. Other topics may include functional difficulties, transition services, shared decision-making and satisfaction with care. Interviews were conducted with parents or guardians who know about the child’s health. Strict confidentiality and privacy regulations apply to all contract and federal project staff for all data collected in this survey.

**Examination Components:** Telephone survey. The primary goals of this survey is to assess the prevalence and impact of special health care needs among children in the U.S. and to evaluate change over time. Demographic information is collected for each selected child; this includes access to health services, insurance and care coordination.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children with special health care needs under age 18 in the 50 states and the District of Columbia	Children from birth to 17 years old	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander	Demographics (including age, sex, race/ethnicity, household income, parental education, family structure, primary language spoken in the home), health and functional status, access to care, and health insurance.	State	2000-2001; 2005-2006; 2009-2010	Yes, available at: <a href="http://www.cdc.gov/nchs/slait/cshcn.htm">http://www.cdc.gov/nchs/slait/cshcn.htm</a>	Yes, available at: <a href="http://www.cdc.gov/nchs/slait/cshcn.htm">http://www.cdc.gov/nchs/slait/cshcn.htm</a>  The NS-CSHCN Chartbook 2009-2010 is available at <a href="http://mchb.hrsa.gov/cshcn0910/">http://mchb.hrsa.gov/cshcn0910/</a>

**Data Source: National Survey of Early Childhood Health (<http://www.cdc.gov/nchs/slait/nsech.htm>)**

**Brief Description:** The National Survey of Early Childhood Health (NSECH) was conducted with parents and guardians most responsible for the health care of children ages 0-17. This survey provides national baseline data on pediatric care and its impact from the parent’s perspective. Major funding for this project was provided by a grant to the American Academy of Pediatrics (AAP) from the Gerber Foundation. Additional support was provided by the Maternal and Child Health Bureau and the AAP Friends of Children Fund. The survey oversampled African American and Hispanic children so that results for these groups could have better estimations.

**Examination Components:** Questions focus on the delivery of pediatric care to families with children under 3 years of age and on the promotion of young children’s health by families in their homes.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children under 3 years old (data collected from parents); oversampling of African American and Hispanic children	Children 4 months to 35 months old	Black or African American; White, Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Age, gender, race/ethnicity, doctor visit frequency, health provider characteristics, health status, and provider discussion topics with parents.	National	2000	Yes, <a href="http://www.cdc.gov/nchs/slait/nsech.htm">http://www.cdc.gov/nchs/slait/nsech.htm</a>	List of publications and resources available at <a href="http://www.cdc.gov/nchs/slait/slait_products.htm">http://www.cdc.gov/nchs/slait/slait_products.htm</a> #NSECH2000

**Data Source:** Title V Information System, Dental Reimbursement Programs (<http://hab.hrsa.gov/abouthab/partfdental.html>)

**Brief Description:** Dental Programs (Part F): The data that the Title V Information System (TVIS) collects includes information on patient demographics, distribution of dental procedures, HIV-related collaboration activities and use of reimbursement award. An estimated 125 institutions with post-graduate dental education programs and/or dental residency programs report data on an application form containing 23 questions. Applicants are required to report on all patients. The Dental Reimbursement Program (DRP), first funded in 1994, assists institutions with accredited dental or dental hygiene education programs by defraying their unreimbursed costs associated with providing oral health care to people with HIV. Institutions that participate in the DRP report that unreimbursed costs of care continue to rise. The second program, Community-Based Dental Partnership Program (CBDPP), specifically focused on funding oral health care for people with HIV.

**Examination Components:** All programs must complete information on the following:

- Institution/program and contact information
- Patient demographics and oral health services
- Funding and payment coverage
- Staffing and training

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals living with HIV	Infants/toddlers, children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander	Low income/poverty; housing; health coverage	State	Annual; 2002-present	Yes	Yes, the Dental Services Report submission deadline is July of every year.

**Data Source:** Title V Information System (<https://mchdata.hrsa.gov/tvisreports/Default.aspx>) and Title V Maternal and Child Health Services Block Grant Program (<http://mchb.hrsa.gov/programs/titlevgrants/index.html>)

**Brief Description:** The Title V Information System (TVIS) electronically captures data from annual Title V Block Grant applications and reports submitted by all 59 U.S. states, territories, and jurisdictions, and provides information on measures and indicators of maternal and child health (MCH) in the United States.

The web-based system allows the states to report their data and state narratives directly online to the Maternal and Child Health Bureau (MCHB). The system includes built-in checks and validations to ensure data quality. Title V seeks to improve the health of all mothers and children—including children with special health care needs—by assessing needs, setting priorities, and providing programs and services. Besides reporting on vital statistics, health indicator and performance measure data, each state also writes an annual narrative that discusses the status and activities of its MCH programs within the context of its data. Information on States’ Title V program can be accessed at <https://mchdata.hrsa.gov/tvisreports/ProgramData/ProgramMenu.aspx>

**Examination Components:** Access to quality care for those with low incomes or limited availability of care. Title V seeks to improve the health of all mothers and children (including children with special health care needs) by assessing needs, setting priorities and providing programs and services.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All	Infants/toddlers; children; youth (early teens to 18 years old); young adults (18 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	Black or African American; White; Hispanic or Latino (of any race); Other; Don't Know	All States are required to report on a core set of measures. These measures include performance and outcome measures. States also are required to report on health systems capacity indicators (see <a href="https://mchdata.hrsa.gov/tvisreports/MeasurementData/MeasurementDataMenu.aspx">https://mchdata.hrsa.gov/tvisreports/MeasurementData/MeasurementDataMenu.aspx</a> ).	National, State	Ongoing	Yes	Yes; available for every year since 2009 at <a href="https://mchdata.hrsa.gov/tvisreports/ProgramData/NumIndiServe.aspx">https://mchdata.hrsa.gov/tvisreports/ProgramData/NumIndiServe.aspx</a>

**Data Source: Title V Maternal and Child Health Services Block Grant Accountability Program**

(<http://mchb.hrsa.gov/programs/titlevgrants/index.html>)

**Brief Description:** Title V of the Social Security Act authorizes appropriations to states to improve the health of all mothers and children consistent with the applicable health status goals, national health status goals and national health objectives established by the Secretary under the Public Health Service Act and Healthy People 2010. The information collected from the Application for Block Grant funds includes data on each state’s needs, priorities, program activities, performance measures and outcomes to be compiled and compared with information from other states. The data collected are used to generate reports to Congress. The unit of analysis is at the state or population. Title V converted to a Block Grant Program in 1981. Specifically, the Title V Maternal and Child Health program seeks to: 1) Assure access to quality care, especially for those with low-incomes or limited availability of care; 2) Reduce infant mortality; 3) Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); 4) Increase the number of children receiving health assessments and follow-up diagnostic and treatment services; 5) Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children; 6) Implement family-centered, community-based systems of coordinated care for children with special health care needs; and 7) Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

**Examination Components:** Numerator: The number of newborns screened and confirmed with condition(s) mandated by the state-sponsored newborn screening program that received timely follow-up to definitive diagnosis and clinical management. Denominator: The number of newborns screened and confirmed with condition(s) mandated by the state-sponsored newborn screening program.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Entire maternal and child health population	Entire maternal and child health population	Black or African American, White, Hispanic or Latino (of any race), Native American, Asian or Pacific Islander	—	National/State	Annual 2007 - present	Yes, available at <a href="http://mchb.hrsa.gov/">http://mchb.hrsa.gov/</a> ; (General Info:) <a href="http://aspe.hhs.gov/datacncl/DataDir/hrsa.htm#BGA">http://aspe.hhs.gov/datacncl/DataDir/hrsa.htm#BGA</a>	National Data Reports range annually from 2008-2011, and 2007-2011. State Data Reports range annually from 1998-2011.

**Data Source: Uniform Data System** (<http://bphc.hrsa.gov/datareporting/index.html>)

**Brief Description:** The Uniform Data System (UDS) is a core system of information appropriate for reviewing the operation and performance of health centers. UDS is a reporting requirement for Health Resources and Services Administration (HRSA) grantees, including community health centers, migrant health centers, health care for the homeless grantees, and public housing primary care grantees. The data are used to improve health center performance and operation and to identify trends over time. UDS data also inform health center programs, partners and communities about the patients served by the centers.

**Examination Components:** The Program Assistance Letter 2013 added reporting patients by ZIP code, age, insurance source, patient demographics, services provided, staffing, clinical indicators, utilization rates, costs and revenues. UDS data are compared with national data to review differences between the United States population at large and those individuals and families who rely on the health care safety net for primary care.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All populations	Infants/toddlers; children; youth (early teens to 18 years old), young adults (18-24 years); adults (25-64 years); and older adults (65 years and older)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; More Than One Race	Low income/poverty; homeless individuals; agricultural workers; residents of public housing	State	Annually since 2006	Available publicly at: <a href="http://datawarehouse.hrsa.gov/data/dataDownload.aspx">http://datawarehouse.hrsa.gov/data/dataDownload.aspx</a>	Data are reported annually in the first quarter of the year. The UDS submission deadline is February 15 every year.

**Data Source: United Network of Organ Sharing (<http://www.unos.org/donation/index.php?topic=data>)**

**Brief Description:** Under contract with HRSA, the United Network of Organ Sharing (UNOS) has operated the Organ Procurement and Transplantation Network (OPTN) since 1986 and operated the Scientific Registry of Transplant Recipients (SRTR) from 1987 until 2000. Prior to September 2000, both OPTN and SRTR were involved in data collection; OPTN collected pre-transplant data, and SRTR collected post-transplant data. Since September 2000, the OPTN contractor has collected all transplant data. The data in its entirety is provided to the SRTR contractor, the University Renal Research and Education Association. The OPTN and SRTR contractors collaborate and share data to support important policy issues in organ transplantation. The data collected and analyzed include information on cadaveric and living donor characteristics, survival rates, waiting lists and organ disposition. Data are provided by transplant programs, histocompatibility laboratories, and organ procurement organizations throughout the United States.

**Examination Components:** Waitlist; deceased donation; live donation; transplant; donor-recipient matching; outcomes; immunosuppression; pediatric transplant; maps of transplant centers.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All national donors/recipients	All	All races/ethnicities	–	Transplant Center	Annual: 2006-2012; UNOS developed an online database system called UNetsm, for the collection, storage, analysis and publication of all OPTN data pertaining to the patient waiting list, organ matching and transplants. Launched on October 25, 1999, this system contains data regarding every organ donation and transplant event occurring in the U.S. since October 1, 1987. UNet is a fail-safe, 24/7, secure Internet-based transplant information	Available by request at: <a href="http://www.srtr.org/data_request/Default.aspx">http://www.srtr.org/data_request/Default.aspx</a>	Program-Specific Report: Cohorts in the January 2013 reports span from 2006-2012; Scientific Registry of Transplant Recipients works jointly with the Organ Procurement and Transplantation Network (OPTN) to develop an Annual Data Report: (annually) 2003-2010; <u>National Data</u> : Includes the latest data about the status of U.S. organ donation and transplantation on a national level; <u>Regional Data</u> : Allows viewing the latest data about the status of U.S. organ donation and transplantation by UNOS region of center; <u>State Data</u> : Allows viewing the latest data about the status of U.S. organ

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
					<p>database created to enable the nation’s organ transplant institutions to register patients for transplants; match donated organs to waiting patients; manage the time-sensitive, life-critical data of all patients, before and after their transplants. UNet is being used by all of the nation’s organ transplant programs, organ procurement organizations and histocompatibility (tissue typing) laboratories working cooperatively to efficiently share a limited number of donated organs among thousands of patients.</p>		<p>donation and transplantation by state of center;  <u>Center Data</u>: Includes current and historical information accumulated about individual transplant centers;  <u>Build Advanced Report</u>: Allows viewing the latest data about the status of U.S. organ donation and transplantation. Can choose from a number of criteria to create a custom report;  <u>Annual Report Data</u>: As part of an ongoing effort to identify emerging trends in the field of organ donation and transplantation, more than 50 experts from many areas of the transplant community have prepared the comprehensive report of the Organ Procurement and Transplantation and U.S. Scientific Registry of Transplant Recipients.</p>

**Data Source: Sickle Cell Disease Treatment Demonstration Program**

(<http://sicklecell.nichq.org/solutions/sickle%20cell%20disease%20treatment%20demonstration%20program>)

**Brief Description:** In 2004, Congress enacted the American Jobs Creation Act of 2004, which authorized a demonstration program for the prevention and treatment of sickle cell disease (SCD). The Sickle Cell Disease Treatment Demonstration Program (SCDTP) is designed to improve and expand patient and provider education and the continuity and coordination of service delivery for individuals with SCD through grants to eligible entities. It aims to improve access to services for individuals with sickle cell disease by providing an opportunity for Federally Qualified Health Centers (FQHCs),

FQHC Look-Alikes and other primary care clinics to partner with comprehensive SCD centers and community-based SCD organizations to deliver high quality clinical care.

As the national coordinating center for the SCDTDP, the National Institute for Children’s Health Quality (NICHQ) works with four regional teams from across the country to increase the number of providers treating persons for SCD or sickle cell-related issues, increase the number of providers prescribing disease modifying therapies (such as hydroxyurea) and increase the number of sickle cell patients who are receiving regular care with providers knowledgeable about treating SCD.

**Examination Components:** Addressing the knowledge gaps that exist in the FQHCs and other primary care settings.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with sickle cell disease	All	All, with predominance of African Americans/Blacks	Sociodemographic characteristics	—	This project began in October 2010 and is scheduled to end in September 2014. The learning collaborative will run from 2011 to 2014. Additional funding has been awarded through 2017.	Yes	The first collaborative session was held in March 2009 and focused on Family/Patient-Center Medical Home Care Model, the model for improvement, and the importance of developing community partnerships. A second session, emphasizing consumer participation was held in November of 2009. The next phase of the collaborative begin with a Quality Improvement workshop in the spring of 2011. Need to register in order to access data.



# Department of Health and Human Services Indian Health Service



**Data Source: National Data Warehouse (<http://www.ihs.gov/NDW/>)**

**Brief Description:** The National Patient Information Reporting System (NPIRS) instituted the National Data Warehouse (NDW) in 2006. NDW is a state-of-the-art, enterprise-wide data warehouse environment for the Indian Health Service’s (IHS) national data repository.

**Examination Components:** Registration data includes patient identification; chart numbers and locations; address; social security number; tribal membership and benefit class; insurance; eligibility; and alias (a.k.a. names). Encounter data includes admission and discharge dates; patient data; location (facility/clinic) of the service; provider discipline; procedure, diagnosis, injury and dental codes; lab tests and clinical measurements; health factors; patient education; medication; and contract health service data such as authorization number, authorizing facility and cost.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indians and Alaska Natives who live in the IHS Service Area or are seen by its health facilities which report data to the NDW	All age groups	American Indians and Alaska Natives	Medical records of a health plan	Location of IHS facility	Since October 1, 2000	Inquire with National Institutional Review Board; no direct access given; data requests are managed by an extensive national process.	Trends in Indian Health; Regional Differences in Indian Health; Indian Health Focus reports. Current copies available at: <a href="http://www.ihs.gov/dps">www.ihs.gov/dps</a>



## Department of Health and Human Services National Institutes of Health



**Data Source:** Action to Control Cardiovascular Risk in Diabetes (<https://biolincc.nhlbi.nih.gov/studies/accord/>)

**Brief Description:** The purpose of this study, Action to Control Cardiovascular Risk in Diabetes (ACCORD), was to determine if intensive glycemic control, multiple lipid management and intensive blood pressure control could prevent major cardiovascular events (myocardial infarction, stroke, or cardiovascular death) in adults with type 2 diabetes mellitus. Secondary hypotheses included treatment differences in other cardiovascular outcomes, total mortality, microvascular outcomes, health-related quality of life and cost-effectiveness.

**Examination Components:** Baseline physical exam, demographics, health utilities, physical activities, medications, and diet.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients with type 2 diabetes mellitus, plus a history of cardiovascular disease or two risk factors for cardiovascular disease	Adults (40 years to 79 years)	White; non-White (race/ethnicity not available in Public Use Dataset)	Education; health insurance	–	1999-2009	Yes, available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/accord/">https://biolincc.nhlbi.nih.gov/studies/accord/</a> )	List of study publications available at <a href="https://biolincc.nhlbi.nih.gov/static/studies/accord/Publications.pdf">https://biolincc.nhlbi.nih.gov/static/studies/accord/Publications.pdf</a>

**Data Source: Activity Counseling Trial** (<https://biolincc.nhlbi.nih.gov/studies/act/>)

**Brief Description:** The objectives of the Activity Counseling Trial (ACT) were to compare the effects of two physical activity counseling interventions with current recommended care and with each other in a primary care setting.

**Examination Components:** Demographics; medical history; activities inventory; medications; graded exercise test; heart rate variability; pulse wave velocity.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients of physicians, physician assistants, or nurse practitioners of 11 primary care facilities affiliated with three clinical centers (California, Texas and Tennessee) and without clinical CVD	Adults (35 years to 75 years)	White or Caucasian; Black or African American; American Indian or Native American; Native Alaskan; Aleutian; Asian or Pacific Islander; Other	Education; income, marital status; employment status; occupation; some area characteristics	–	1994-2002	Yes; available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/act/">https://biolincc.nhlbi.nih.gov/studies/act/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Activity+Counseling+Trial+%28ACT%29&amp;acronym=ACT">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Activity+Counseling+Trial+%28ACT%29&amp;acronym=ACT</a>

**Data Source: Alcohol Epidemiologic Data Directory** (<http://pubs.niaaa.nih.gov/publications/2012DataDirectory/2012DataDirectory.htm#1>)

**Brief Description:** This Alcohol Epidemiologic Data Directory is compiled and updated by the Alcohol Epidemiologic Data System (AEDS) and is operated by CSR Incorporated under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA). AEDS’s task is to identify, acquire, maintain and analyze alcohol-related epidemiologic data under the direction of NIAAA. Analytical results from datasets described in this directory often are available on the Internet in tabular or summary form. Some data sets can be analyzed online with programs provided by the sponsoring organization.

**Examination Components:** This directory is a current listing of surveys and other relevant data suitable for epidemiologic research on alcohol. Some surveys included in the directory are designed specifically to answer alcohol-related questions. Other surveys may address other issues but still contain alcohol-related data.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The first section of the directory includes datasets that are representative of the overall U.S. population, although many use different age categories in the sample design. The second section includes datasets on special populations (e.g., adolescents, prison inmates, military personnel, older Americans and specific racial or ethnic groups).	Variable depending on dataset	Starting in the 1970's depending on the dataset	Analytical results often are available on the Internet in tabular or summary form. Some data sets can be analyzed online with programs provided by the sponsoring organization.	Alcohol Epidemiologic Data Directory available at <a href="http://pubs.niaaa.nih.gov/publications/2012DataDirectory/2012DataDirectory.htm#1">http://pubs.niaaa.nih.gov/publications/2012DataDirectory/2012DataDirectory.htm#1</a>			

**Data Source: Atherosclerosis Risk in Communities Study** (<http://www.nhlbi.nih.gov/resources/obesity/pop-studies/aric.htm>)

**Brief Description:** The Atherosclerosis Risk in Communities Study (ARIC) is designed to investigate the etiology and natural history of atherosclerosis; the etiology of clinical atherosclerotic diseases; and variation in cardiovascular risk factors, medical care and disease by race, gender, location and date. Prospective epidemiologic study of cardiovascular disease among middle-aged persons in four United States Communities (15,792 participants). Five examinations were given, the most recent in 2011-2013 with mortality and morbidity follow-up. Education and income were determined by self-report. Current contract objectives include:

1. Examine the ARIC cohort to characterize heart failure stages in the community, identify genetic and environmental factors leading to ventricular dysfunction and vascular stiffness, and assess longitudinal changes in pulmonary function and identify determinants of its decline.
2. Cohort follow-up for cardiovascular events, including coronary heart disease (CHD), heart failure, stroke and atrial fibrillation, for the study of risk factors related to progression of subclinical to clinical cardiovascular disease (CVD).
3. Enhance the ARIC cohort study with cardiovascular outcomes research to assess quality and outcomes of medical care for heart failure and heart failure risk factors.
4. Community surveillance to monitor long-term trends in hospitalized myocardial infarction (MI), CHD deaths and heart failure (inpatient and outpatient).
5. Provide a platform for ancillary studies, training for new investigators and data sharing.

**Examination Components:** ARIC includes two parts: the Cohort Component and the Community Surveillance Component. The Cohort Component began in 1987, and each ARIC field center randomly selected and recruited a cohort sample of approximately 4,000 individuals aged 45-64 from a defined population in their community. A total of 15,792 participants received an extensive examination, including medical, social and demographic data. These participants were reexamined every three years from 1987 to 1998, with the first screen (baseline) occurring in 1987-1989, the second in 1990-1992, the third in 1993-1995, and the fourth in 1996-1998. In 2011-2013, a fifth exam was conducted on more than 6,500 surviving participants 69-89 years old. Follow-up occurs yearly by telephone to maintain contact with participants and to assess health status of the cohort. In the Community Surveillance Component currently ongoing, these four communities are investigated to determine the community-wide occurrence of hospitalized MI and CHD deaths in men and women aged 35-84 years. Hospitalized stroke is investigated in cohort participants only. The study conducts community surveillance of inpatient heart failure (ages 55 years and older) and cohort surveillance outpatient heart failure events beginning in 2005. To date, the ARIC project has published over 1,300 articles in peer-reviewed journals and other summary reports of ARIC data at various national and international scientific conferences and meetings.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults (See additional details under “Examination Component” above)	Adults ages 45-64 years old at baseline exam in 1987	Primarily Black and White adults. Self-assessed race includes White; Black; Asian and Pacific Islanders; Native American; and Hispanic	Family income; household income; education level; occupation; marital status	Four sites are Washington County, MD; Forsyth County, NC; Jackson, MS; and Minneapolis, MN	Cohort Component: 1987-1998 Community Surveillance Component: 2005-ongoing (as of 2015)	Available publicly at: <a href="http://www.2.csc.unc.edu/aric/">http://www.2.csc.unc.edu/aric/</a>	<ul style="list-style-type: none"> <li>• Annual Heart Disease and Stroke Statistical Update</li> <li>• Dietary Guidelines for Americans</li> <li>• HHS Physical Activity Guidelines for Americans</li> <li>• The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity</li> <li>• White House Report on Childhood Obesity</li> <li>• The Let’s Move Initiative</li> <li>• National Collaborative on Childhood Obesity Research: <a href="http://www.nhlbi.nih.gov/resources/obesity/reports.htm">http://www.nhlbi.nih.gov/resources/obesity/reports.htm</a></li> </ul>

**Data Source: Cardiovascular Health Study (<http://chs-nhlbi.org>)**

**Brief Description:** The Cardiovascular Health Study (CHS) is a prospective epidemiologic study of cardiovascular disease in older persons in four United States communities for a total of 5,201 participants. Repeat examinations and mortality and morbidity follow-up were conducted to identify risk factors for cardiovascular disease (CVD). The Cardiovascular Health Study is an NHLBI-funded observational study of risk factors for CVD in adults 65 years or older. Starting in 1989 and continuing through 1999, participants underwent annual, extensive clinical examinations.

**Examination Components:** Measurements included traditional risk factors such as blood pressure and lipids as well as measures of subclinical disease, including echocardiography of the heart, carotid ultrasound and cranial magnetic-resonance imaging (MRI). At six-month intervals between clinic visits and once clinic visits ended, participants were contacted by phone to ascertain hospitalizations and health status. The main outcomes are coronary heart disease (CHD), angina, heart failure (HF), stroke, transient ischemic attack (TIA), claudication and mortality. Participants continue to be followed for these events. The main objective of the study is to identify factors related to the onset of coronary heart disease and stroke. CHS is designed to determine the importance of conventional CVD risk factors in older adults and to identify new risk factors in this age group, especially those that may be protective and modifiable. Other objectives are to:

1. Quantify associations of conventional and hypothesized risk factors with CHD and stroke.
2. Assess the association of indicators of subclinical disease, identified by noninvasive measures such as carotid ultrasonography and echocardiography, with incidence of CHD and stroke.
3. Quantify the association of conventional and hypothesized risk factors with subclinical disease.
4. Characterize the natural history of CHD and stroke, and identify factors associated with clinical course.
5. Describe the prevalence and distributions of risk factors, subclinical disease and clinically diagnosed CHD and stroke. Data were collected through semi-annual phone calls, events adjudication and subsequent data analyses and publications. Additional data were collected by studies ancillary to CHS. (Example: Thursday,2011-12-15 12:32 America/Los\_Angeles — Anonymous (not verified Combined Cohort at Baseline (N=5888) Mean Age = 72 years 58% Women 16% African American 31% had Cardiovascular Disease at entry.)

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
In June 1990, four Field Centers completed the recruitment of 5,201 participants. Between November 1992 and June 1993, an additional 687 African Americans were recruited using similar methods.	Adults 65 years and older	Self-assessed: White, Black, American Indian or Alaska Native, Asian or Pacific Islander	Education; occupation; income group; marital status	Community and Field Centers: <ul style="list-style-type: none"> <li>• Sacramento County, Sacramento, CA - University of California, Davis</li> <li>• Washington County, Hagerstown, MD - Johns Hopkins University</li> <li>• Forsyth County, Winston-Salem, NC - Wake Forest University School of Medicine</li> <li>• Pittsburgh, PA - University of Pittsburgh</li> </ul>	Study originated in 1988; renewed for another six years in 1994; renewed again for continued morbidity and mortality follow-up	Data are available upon request from NHLBI Data repository (BioLINCC: <a href="https://biolincc.nhlbi.nih.gov/studies/chs/">https://biolincc.nhlbi.nih.gov/studies/chs/</a> ) or through a collaboration with study investigators	October 2009: <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/</a> (dup)  Study results available in medical journal publications. <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/</a>

**Data Source: Collaborative Psychiatric Epidemiology Surveys (<http://www.icpsr.umich.edu/icpsrweb/CPES>)**

**Brief Description:** The Collaborative Psychiatric Epidemiology Surveys (CPES), with support from the National Institute on Mental Health (NIMH), were initiated in recognition of the need for contemporary, comprehensive, epidemiological data regarding the distributions, correlates and risk factors of mental disorders among the general population, with special emphasis on minority groups. The primary objective of CPES was to collect data about the prevalence of mental disorders, impairments associated with these disorders, and their treatment patterns from representative samples of majority and minority adult populations in the United States. Secondary goals were to obtain information about language use and ethnic disparities, support systems, discrimination and assimilation in order to examine whether and how closely various mental health disorders are linked to social and cultural issues. To this end, CPES joins together three nationally representative surveys: the National Comorbidity Survey Replication (NCS-R); the National Survey of American Life (NSAL); and the National Latino and Asian American Study (NLAAS). These studies collectively provide the first national data with sufficient power to investigate cultural and ethnic influences on mental disorders. In this manner, CPES permits analysts to approach analysis of the combined dataset as though it were a single, nationally representative study. Each of the CPES studies has been documented in a comprehensive and flexible manner that promotes cross-survey linking of key data and scientific constructs. Each study represents an important exploration of the mental health status of specific populations. The following provides a brief description of each of the studies:  
[http://www.icpsr.umich.edu/icpsrweb/CPES/about\\_cpes/background.jsp](http://www.icpsr.umich.edu/icpsrweb/CPES/about_cpes/background.jsp).

**Examination Components:** Interviews; response rate (percent); average interview length (minutes); average contacts per interview; National Comorbidity Survey Replication (NCS-R) Main respondent Second respondent; National Survey of American Life (NSAL) Adult respondent; National Latino and Asian American Study (NLAAS); Main respondent; Second respondent.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
<b>National Comorbidity Survey Replication (NCS-R):</b> All adults, age 18+ residing in households in the coterminous United States; exclusions include institutionalized persons,	Adults 18 years and older	Black or African American; White; Hispanic or Latino (of any race);	Education; questions about ability to pay bills or for food; employment.  Feeling close in your ideas/feelings with	Census tract	2001-2003	Available publicly at: <a href="http://www.icpsr.umich.edu/icpsrweb/CPES/studies/20240">http://www.icpsr.umich.edu/icpsrweb/CPES/studies/20240</a> Restricted data sites available to apply for access:	Study publications are available at <a href="http://www.ic">http://www.ic</a>

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
<p>those living on military bases and non-English speakers.</p> <p><b>National Survey of American Life (NSAL):</b> African American, Afro-Caribbean and non-Hispanic White adults, age 18+ residing in households in the coterminous United States; exclusions include institutionalized persons, those living on military bases and non-English speakers.</p> <p><b>National Latino and Asian American Study (NLAAS):</b> Latino and Asian-American adults, age 18+ residing in households in the coterminous United States, Alaska and Hawaii; exclusions include institutionalized persons and those living on military bases.</p>		Native American; Asian or Pacific Islander; Other	<p>same racial descent .</p> <p>Amount of time would like to spend w same racial/ethnic group .</p> <p>Importance for same racial/ethnic group to marry within group .</p> <p>Citizen of the United States. Citizenship in another country;</p> <p>Religious preferences.</p> <p>Frequency attending religious services.</p> <p>Importance of religious beliefs in daily life; (<a href="http://www.icpsr.umich.edu/icpsrweb/CPES/files/cpes/sections/BLDEMOGRAP_DA">http://www.icpsr.umich.edu/icpsrweb/CPES/files/cpes/sections/BLDEMOGRAP_DA</a>)</p>			<ul style="list-style-type: none"> <li>•NCSR Restricted Dataset (Excel 75K)</li> <li>•NSAL Restricted Dataset (Excel 52K)</li> <li>•NLAAS Restricted Dataset (Excel 66K)</li> <li>•CPES Restricted Crosswalk (Excel 109K)</li> </ul> <p><a href="https://www.icpsr.umich.edu/rpxlogin">https://www.icpsr.umich.edu/rpxlogin</a></p>	psr.umich.edu/icpsrweb/ICPSR/studies/20240#pubs

**Data Source: Coronary Artery Risk Development in Young Adults** (<https://www.nhlbi.nih.gov/resources/obesity/pop-studies/cardia.htm>)

**Brief Description:** The Coronary Artery Risk Development in Young Adults (CARDIA) is a prospective epidemiologic study of young adults in four United States communities (5,115 participants). Repeat examinations were given to determine the prevalence and change in cardiovascular risk factors. CARDIA is a long-term study examining the evolution of cardiovascular disease (CVD) risk factors in young adults. The new analysis indicates that fiber consumption is independently and inversely associated with insulin levels, weight gain and other CVD risk factors among healthy, young black and white adults. It began in 1985-1986 with a group of 5,115 black and white men and women aged 18-30 years. The participants were selected so that there would be approximately the same number of people in subgroups of race, gender, education (high school or less and more than high school) and age (18-24 and 25-30) in each of four centers: Birmingham, AL; Chicago, IL; Minneapolis, MN; and Oakland, CA. These same participants were asked to participate in follow-up examinations during 1987-1988 (Year 2), 1990-1991 (Year 5), 1992-1993 (Year 7), 1995-1996 (Year 10), 2000-2001 (Year 15) and 2005-2006 (Year 20). A majority of the group has been examined at each of the follow-up examinations (90%, 86%, 81%, 79%, 74% and 72%, respectively).

**Examination Components:** Examinations conducted at years 2, 5, 7, 10, 15, 20 and 25 years after enrollment. Wide range of demographics, employment, behavioral questionnaires, physical examination, diet histories, physical activity and laboratory data. While the specific aims of each examination have varied, data have been collected on a variety of factors believed to be related to heart disease. These include conditions with clear links to heart disease such as blood pressure, cholesterol and other lipids, and glucose. Data have also been collected on physical measurements such as weight and skinfold fat as well as lifestyle factors such as substance use (tobacco and alcohol), dietary and exercise patterns, behavioral and psychological variables, medical and family history, and other chemistries (e.g., insulin). In addition, subclinical atherosclerosis was measured via echocardiography during years 5 and 10, computed tomography during years 15 and 20, and carotid ultrasound during year 20.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The CARDIA Study, a multicenter, population-based study, is following young Black and White adults in four U.S. areas: Birmingham, AL; Chicago, IL; Minneapolis, MN; and Oakland, CA	Adults 18-24; 25-30 years old (at entry)	White and non-White. See additional information under "Brief Description" above.	Family income; education; occupation; marital status; health insurance	City: Birmingham, AL; Chicago, IL; Minneapolis, MN; and Oakland, CA	1985-2011	Available publicly upon request at: <a href="http://www.cardia.dopm.uab.edu/">http://www.cardia.dopm.uab.edu/</a> or through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/cardia/">https://biolincc.nhlbi.nih.gov/studies/cardia/</a> )	Study results available in medical journal publications; A report of this analysis, "Dietary Fiber, Weight Gain, and Cardiovascular Disease Risk Factors in Young Adults," appears in the October 27, 1999 edition of the Journal of the American Medical Association (JAMA).

**Data Source:** Enhancing Recovery in Coronary Heart Disease Patients (<https://biolincc.nhlbi.nih.gov/studies/enrichd/>)

**Brief Description:** The objective of the Enhancing Recovery in Coronary Heart Disease Patients (ENRICH) study was to determine whether mortality and recurrent infarction are reduced by treatment of depression and low perceived social support with cognitive behavior therapy, supplemented with a selective serotonin reuptake inhibitor antidepressant, when indicated, in patients enrolled within 28 days after myocardial infarction.

**Examination Components:** Demographics; medical history; social support questionnaire; depression questionnaire.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients within 28 days of an acute myocardial infarction	Adults (34 years to 85 years)	White; Black; Hispanic; Other	Income; marital status; employment status	Region	1995-2005	Yes, through the NHLBI data repository	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Enhancing+Recovery+in+Coronary+Heart+Disease+Patients+%28ENRICH+HD%29&amp;acronym=ENRICH">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Enhancing+Recovery+in+Coronary+Heart+Disease+Patients+%28ENRICH+HD%29&amp;acronym=ENRICH</a>

**Data Source: Epidemiologic Catchment Area Program** (<http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1>)

**Brief Description:** The National Institute of Mental Health (NIMH) Epidemiologic Catchment Area program (ECA) was initiated in response to the 1977 report of the President’s Commission on Mental Health. The purpose was to collect data on the prevalence and incidence of mental disorders and on the use of and need for services by the mentally ill. Independent research teams at five universities—Yale University, Johns Hopkins University, Washington University at St. Louis, Duke University, and University of California at Los Angeles (UCLA)—in collaboration with NIMH, conducted the studies with a core of common questions and sample characteristics. The sites were areas that had previously been designated as Community Mental Health Center catchment areas: New Haven, CT; Baltimore, MD; St. Louis, MO; Durham, NC; and Los Angeles, CA. Each site sampled over 3,000 community residents and 500 residents of institutions, yielding 20,861 respondents overall. The longitudinal ECA design incorporated two waves of personal interviews administered one year apart and a brief telephone interview in between (for the household sample). The diagnostic interview used in the ECA was the NIMH Diagnostic Interview Schedule (DIS), Version III (with the exception of the Yale Wave I survey, which used Version II). Diagnoses were categorized according to the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III). Diagnoses derived from DIS include manic episode, dysthymia, bipolar disorder, single episode major depression, recurrent major depression, atypical bipolar disorder, alcohol abuse or dependence, drug abuse or dependence, schizophrenia, schizophreniform, obsessive compulsive disorder, phobia, somatization, panic, antisocial personality, and anorexia nervosa. DIS uses the Mini-Mental State Examination, which measures cognitive functioning, as an indirect measure of the DSM-III Organic Mental Disorders. In the ECA survey, this diagnosis is called cognitive impairment.

**Examination Components:** Two waves of interviews one year apart with a telephone interview to capture additional service use information at the six-month interval between the two interviews. The data was collected by five universities—Yale University, Johns Hopkins University, Washington University at St. Louis, Duke University, and UCLA.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Persons aged 18 and older residing in New Haven, Connecticut, Baltimore, Maryland, St. Louis, Missouri, Durham, North Carolina, and Los Angeles, California. (Regarding Multistage probability Sampling): New Haven, Durham, and Baltimore oversampled elderly respondents. St. Louis oversampled Blacks, and Los Angeles sampled Hispanics within their minimum required sample size; Each site sampled over 3,000 community residents and 500 residents of institutions, yielding 20,861 respondents overall.	Adults age 18 and over	American Indian; Alaska Native; Asian; Pacific Islander; Black (not Hispanic); Hispanic; White (not Hispanic); Other; Don't Know; Refused/Not Applicable; Skipped	Education; occupation; and income	Census tract (Community Mental Health Center catchment areas: New Haven, CT; Baltimore, MD; St. Louis, MO; Durham, NC; and Los Angeles, CA)	1980-1985	Yes, computer tapes (Accession Number available online: <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1#datasetsSection">http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1#datasetsSection</a> )	Study publications available at <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1#pubs">http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1#pubs</a>

**Data Source: Established Populations for Epidemiologic Studies of the Elderly** (<http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915>)

**Brief Description:** The Established Populations for Epidemiologic Studies of the Elderly (EPESE) were developed to provide an epidemiologic resource for the conduct of a broad range of studies in representative samples of community-dwelling persons age 65 years and older. The goal of these studies has been to investigate the association of numerous factors (including medical conditions, demographic characteristics, social and psychological factors, medication use and health behaviors) with important outcomes in aging populations, including death, disability, nursing home admission and the onset of new chronic conditions. The three original community populations comprising the EPESE were located in East Boston, MA; Iowa and Washington Counties, IA; and New Haven, CT. Baseline data collection began in December 1981, and annual interviews were conducted either in person (third and sixth years of follow-up) or by telephone (first, second, fourth and fifth years of follow-up) for six years following the baseline. A five-year extension contract that expired in early 1994 in each of these sites provided the opportunity for data clean-up, continued monitoring of mortality through the National Death Index and monitoring of hospital utilization through linkage to Medicare records from the Health Care Financing Administration (HCFA) (which became the Centers for Medicare & Medicaid Services in 2001). The Piedmont Health Survey of the Elderly was added as the fourth site of the EPESE project in 1985. In this site, Duke University established a baseline sample of 4,164 people 65 years of age and older, 54 percent of whom were black. This cohort is the only southern EPESE population, constitutes a representative sample of the elderly in five North Carolina counties, and includes both urban and rural participants. The baseline survey for this site began in January of 1986 and was completed in June 1987. Six annual follow-up evaluations have been completed since then, by telephone and in person, on the same schedule as the original EPESE sites. A seven-year contract was awarded to Duke University Medical Center on January 1, 1991 to conduct the third in-person survey wave and to continue surveillance for major endpoints using the National Death Index and HCFA hospitalization data tapes after direct contact with subjects was completed.

**Examination Components:** Epidemiology, demography and biometry program. Participants were asked, "Please give me the number of the group or groups which describes your racial background? What is your race?" The Health and Retirement Study (HRS) includes 100 percent oversamples of Hispanics and Blacks. The questions used to collect this information are as follows:

- In what country were you born?
- In about what year did you come to the U.S.?
- Do you consider yourself Hispanic or Latino? Inapp, Yes, No, DK, RF
- Would you say you are Mexican American, Puerto Rican, Cuban American or something else? Inapp, Mexican American/Chicano, Puerto Rican, Cuban American, Other, DK, RF
- Do you consider yourself primarily White or Caucasian, Black or African American, American Indian or Asian, or something else? Inapp, White/Caucasian, Black/African American, American Indian or Alaska Native, Asian or Pacific Islander, Other, DK, RF

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults (65+; non-institutionalized; East Boston, MA; Iowa and Washington Counties, IA; New Haven, CT; and North Central, NC)	Adults 65-69, 70-74, 75-79, 80-84, 85 years and older; age not stated	Black or African American; White; Other; Not Available; Don't Know	–	State	1981-1993	Available for download at: <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#datasetsSection">http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#datasetsSection</a>	Study publications available at <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#pubs">http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#pubs</a>

**Data Source:** Health Information National Trends Survey (<http://hints.cancer.gov/>)

**Brief Description:** The Health Information National Trends Survey (HINTS) is a biennial, cross-sectional survey of a nationally representative sample of American adults that is used to assess the impact of the health information environment. The survey provides updates on changing patterns, needs and information opportunities in health; identifies changing communications trends and practices; assesses cancer information access and usage; provides information about how cancer risks are perceived; and offers a testbed to researchers to test new theories in health communication. HINTS was developed by the Health Communication and Informatics Research Branch of the Division of Cancer Control and Population Sciences as an outcome of the National Cancer Institute's Extraordinary Opportunity in Cancer Communications.

**Examination Components:** The HINTS data collection program was created to monitor changes in the rapidly evolving field of health communication. Survey researchers are using the data to understand how adults 18 years and older use different communication channels, including the Internet, to obtain vital health information for themselves and their loved ones. Program planners are using the data to overcome barriers to health information usage across populations and obtaining the data they need to create more effective communication strategies. Finally, social scientists are using the data to refine their theories of health communication in the information age and to offer new and better recommendations for reducing the burden of cancer throughout the population. HINTS data are available for public use.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults aged 18 or older in the civilian non-institutionalized population of the United States. This population is disproportionately related to younger persons.	Adults 18 years and older	Hispanic; White; Black or African American; American Indian or Alaska Native; Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; Other Asian; Native Hawaiian; Guamanian or Chamorro; Samoan; Other Pacific Islander	Occupational status; marital status; education; household income	National: HINTS data provide nationally representative estimates, but there are variables in the data set that allow researchers to compare rural vs. urban metropolitan statistical areas as well as census regions (four total) and census divisions (nine total). Though the data can only be assessed as a representation of the nation, as there are not enough data from each state to analyze them individually, there are certain cases where data can be pooled across multiple iterations of HINTS such that the sample size may increase enough to perform a state-based investigation that is statistically appropriate. Other use cases may involve linking state-level data with HINTS data using a multilevel analysis. Contact the HINTS program if you are interested in obtaining state-level information.	2003-present	Available publicly, after registering, at: <a href="http://hints.cancer.gov/terms.aspx">http://hints.cancer.gov/terms.aspx</a> ( <a href="http://hints.cancer.gov/">&gt;&gt; Data/Instruments &gt;&gt; Download Data</a> )	HINTS Final Reports: <a href="http://hints.cancer.gov/instrument.aspx">http://hints.cancer.gov/instrument.aspx</a>  Briefs can be found here: <a href="http://hints.cancer.gov/briefs.aspx">http://hints.cancer.gov/briefs.aspx</a>  Peer-reviewed publications available at <a href="http://hints.cancer.gov/research.aspx">http://hints.cancer.gov/research.aspx</a>

**Data Source: Health and Retirement Study (<http://www.umich.edu/~hrswww/>)**

**Brief Description:** The Health and Retirement Study (HRS) provides data to researchers, policy analysts and program planners to inform major policy decisions affecting retirement, health insurance, saving and economic well-being. These groups have already made extensive use of HRS to study individual work, savings and retirement decisions and to model behavioral response to changes in Social Security and Medicare benefits. HRS is a national panel study based on biennial interviews. The original sample consists of in-home, face-to-face interviews of persons who were age 51-61 in 1992 and their spouses (7,600 households, over 12,600 persons). Hispanics, Blacks and Florida residents were oversampled. The HRS data collection has incorporated the Asset and Health Dynamics Among the Oldest Old (AHEAD) Study as of 1998. Follow-ups are done by mail/phone every second year. New baseline cohorts (those born in 1942-1947 or in 1924-1930) were added in 1998.

**Examination Components:** HRS is linked with the following administrative data: 1) health and pension benefit plans collected from employers; 2) data from the National Death Index; 3) Social Security Administration earnings and benefits data; and 4) Medicare files when respondents reach Medicare age. Questionnaire topics include health and cognitive conditions and status; retirement plans and perspectives; attitudes, preferences, expectations and subjective probabilities; family structure and transfers; employment status and job history; disability; demographic background; housing; income and net worth; health insurance and pension plans; experimental modules. Next-of-kin provide information on health changes and distribution of assets for deceased respondents. Additional data from employers, Medicare files, the National Death Index and Social Security Administration earnings and benefits files are being linked to interview data.

Data are collected on economic circumstances, occupation and employment, health and health care, cognition, living and housing arrangements, demographics and family relationships. HRS is a national panel study based on biennial interviews. The original sample consists of in-home, face-to-face interviews of persons who were age 51-61 in 1992 and their spouses (7,600 households, over 12,600 persons).

Population Target	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults (over the age of 50) <sup>18</sup>	50 years and older	Black or African American; White; Other/Unknown; Hispanic	Income; work; assets; pension plans; health insurance; disability; physical health and functioning; cognitive functioning; and health care expenditures <sup>19</sup>	State	1992-present (survey conducted every two years, with supplements)	Data products are available without cost to registered users online; certain conditions of use apply: <a href="http://hrsonline.isr.umich.edu/index.php?p=resdat">http://hrsonline.isr.umich.edu/index.php?p=resdat</a>	Link to publications and press releases can be found here: <a href="http://hrsonline.isr.umich.edu/index.php?p=pubs">http://hrsonline.isr.umich.edu/index.php?p=pubs</a>

<sup>18</sup> The HRS includes 100 percent oversamples of Hispanics and Blacks. The questions used to collect this information are as follows:

- In what country were you born?
- In about what year did you come to the U.S.?
- Do you consider yourself Hispanic or Latino? Inapp, Yes, No, DK, RF
- Would you say you are Mexican American, Puerto Rican, Cuban American or something else? Mexican American/Chicano, Puerto Rican, Cuban American, Other, DK, RF

Do you consider yourself primarily White or Caucasian, Black or African American, American Indian or Asian, or something else? Inapp, White/Caucasian, Black/African American, American Indian or Alaska Native, Asian or Pacific Islander, Other, DK, RF

<sup>19</sup> The HRS gathers standard demographic facts such as age, racial/ethnic background, education, marital status and history and family composition. Among married participants, detailed health and economic information is collected from both spouses. General demographic information about HRS participants' parents, children and siblings is also gathered. In addition, survey interviews document the relationships among family members and the nature of intergenerational family supports, including financial transfers, caregiving, joint housing arrangements and time spent with family members.

**Data Source: Honolulu Heart Program ([http://www.kuakini.org/programs/services/pro\\_ResearchPrograms.asp](http://www.kuakini.org/programs/services/pro_ResearchPrograms.asp))**

**Brief Description:** The Honolulu Heart Program (HHP) is a prospective epidemiologic study of cardiovascular disease conducted in Honolulu, HI. A total of 8,006 men participated in repeated examinations and were followed for cardiovascular disease and cancer. Hyperinsulinemia has been associated with cardiovascular disease (CVD), but whether this relation is independent of other CVD risk factors is uncertain. Most studies have focused on coronary heart disease (CHD), but few have included peripheral vascular disease (PVD) and stroke. Moreover, evidence in elderly and minority populations is limited. Between 1991 and 1993, 3,562 elderly (71 to 93 years) Japanese-American men from the Honolulu Heart Program were examined and had fasting insulin levels measured. Hyperinsulinemia, defined as a fasting insulin  $\geq$  95<sup>th</sup> percentile among nonobese men with normal glucose tolerance and no diabetic history or medication use, was observed in 22 percent of the population. Subjects with hyperinsulinemia had a more adverse CVD risk factor profile and had higher age-adjusted prevalence of CHD, angina, PVD, thromboembolic stroke and hemorrhagic stroke compared with those without hyperinsulinemia. Age-adjusted fasting insulin levels, but not two-hour levels, were also significantly elevated ( $P < .01$ ) in those with prevalent CVD compared with those without. In logistic regression analyses, adjustment for multiple CVD risk factors attenuated the relations of hyperinsulinemia with CHD, angina and PVD to nonsignificant levels, whereas those involving thromboembolic and hemorrhagic stroke were strengthened and remained significant (odds ratios=2.27 and 7.53, 95 percent confidence intervals=1.25 to 4.13 and 1.65 to 34.25, respectively). When multivariate analyses were restricted to nondiabetic subjects, associations were slightly weaker and in general nonsignificant. Nondiabetic men with thromboembolic stroke were twice as likely to have hyperinsulinemia as those who were stroke-free, although this association was of borderline significance (odds ratio= 1.99, 95 percent confidence interval=0.95 to 4.17,  $P=.069$ ). In subjects with elevated total cholesterol levels, somewhat stronger associations were observed for PVD and stroke but not for CHD. Although further prospective studies are indicated, particularly for PVD and stroke, these cross-sectional results are consistent with an indirect role for insulin in CVD, wherein hyperinsulinemia or an underlying insulin-resistant state may adversely affect other CVD risk factors or serve as a marker for an atherogenic or thrombogenic state.

**Examination Components:** Examination 1 (1965-1968, N=8,006 participants, average age 54.4). Anthropometry values: weight; standing and sitting height; chest depth; bi-acromial diameter; bi-iliac diameter; upper left arm girth; grip strength each hand; left triceps skinfold; left subscapular skinfold. Physical measures: heart rate; blood pressure sitting; resting (13-lead) electrocardiogram (ECG); forced vital capacity (FVC) and forced expiratory volume in one second (FEV1). Chemistries: urine glucose and protein; hematocrit; casual serum total cholesterol; casual serum triglyceride; casual serum uric acid; one-hour postload serum glucose. Medical history/lifestyle: medical history; history of CHD or stroke; Rose chest pain questionnaire; history of diabetes and medication for diabetes; physical activity index; cigarette smoking history; alcohol consumption history; occupation history. Dietary: ratio measure of Japanese food consumption to total food consumption; 24-hour dietary recall; intake frequency of unusual foods. Family history: questionnaire responses. \*This exam is followed by Examination 2 (1967-70, N=7498 participants, average age 56.4), Examination 3 (1971-74, N=6860 participants, average age 60.2), and Examination 4 (1991-93, N=3845 participants, average age 77.8)—with variances in: anthropometry and

physical measures; chemistries; medical history/lifestyl; and diet; these exams are followed by Lipoprotein Exam I, II, & III; Acculturation Questionnaire, and Jenkins Activity Survey, CASI (Cognitive Abilities Screening Instrument), Surveillance Files.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
<p>Adult men</p> <p>All men in the study were Japanese Americans, American men of Japanese ancestry who were living on the island of Oahu in 1965. (<a href="http://www.bioportfolio.com/resources/trial/125261/Honolulu-Heart-Program.html">http://www.bioportfolio.com/resources/trial/125261/Honolulu-Heart-Program.html</a>)</p>	Adult men (age at entry: 28-62 years)	Asian or Pacific Islander (Japanese-American)	<p>Cultural assimilation of the family which includes: ethnicity of employer, childhood and present friends, participation in Japanese social organizations, fluency in spoken and written Japanese, degree of usage of Japanese to communicate with friends and family members, observance of certain Japanese customs, and the ethnicity of their doctor, dentist, and lawyer.</p> <p>There is also a series of thirty-eight questions measuring the degree of agreement of the participant on statements about Japanese cultural values.</p>	City: Honolulu, Hawaii	1965-1996	Data available upon request through the NHLBI data repository: ( <a href="https://biolinc.nhlbi.nih.gov/studies/hhp/">https://biolinc.nhlbi.nih.gov/studies/hhp/</a> )	Benfante R, Hwang LJ, Masaki K, Curb JD. To what extent do cardiovascular risk factor values measured in elderly men represent their midlife values measured 25 years earlier? A preliminary report and commentary from the Honolulu Heart Program. <i>Am J Epidemiol.</i> 1994 Aug 1;140(3):206-16. ( <a href="http://www.ncbi.nlm.nih.gov/pubmed/8030624?dopt=Abstract">http://www.ncbi.nlm.nih.gov/pubmed/8030624?dopt=Abstract</a> )

**Data Source:** Jackson Heart Study (<https://biolincc.nhlbi.nih.gov/studies/jhs/>)

**Brief Description:** The objectives of the Jackson Heart Study are to 1) investigate the associations of biological, psychosocial and behavioral factors with the incidence of atherosclerotic events and health outcomes in an African American cohort; and 2) increase access to and the participation of African American populations and scientists in biomedical research and professions.

**Examination Components:** Demographics; medical history; behavioral questionnaires; laboratory assessments; physical examination; diet recall; physical activity.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adult Black men and women, residing in the metropolitan area of Jackson, MS (Hinds, Madison and Rankin Counties)	Age 35-84 at entry	African American	Education; income; marital status; health insurance; employment status; occupation	Metropolitan area of Jackson, Mississippi	2000-present	Yes; available upon request, through the Jackson Heart Study or through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/jhs/">https://biolincc.nhlbi.nih.gov/studies/jhs/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=The+Jackson+Heart+Study+%28JHS%29&amp;acronym=JHS">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=The+Jackson+Heart+Study+%28JHS%29&amp;acronym=JHS</a>

**Data Source: Lipid Research Clinics - Prevalence Study (<https://biolincc.nhlbi.nih.gov/studies/lrcps/>)**

**Brief Description:** The Lipid Research Clinics Prevalence Study (LRCPS) was a standardized series of cross-sectional surveys of various North American populations designed to determine the prevalence of dyslipidemias and to describe the distributions of lipids and lipoproteins in major ethnic and social groups. In addition to contributing to the aggregate analysis, each independent population-based study was designed with capabilities for separate analyses of lipid and lipoprotein distributions. The participating populations were not selected to be a probability sample representative of the North American population per se, but by virtue of their size and economic and geographical diversity, they provide a useful cross-sectional group.

**Examination Components:** Demographics and lipid measurements; graded exercise test; family study.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The populations of the study fall into three categories: occupational groups, household or residential groups, and school children and their parents.	Infants/toddlers to older adults (65 years and older)	Black; non-Black	Education; marital status; occupation	Clinic site	1972-1994	Yes, available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/lrcps/">https://biolincc.nhlbi.nih.gov/studies/lrcps/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lipid+Research+Clinics+%28LRC%29+Prevalence+Study+%28PS%29&amp;acronym=LRC-PS">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lipid+Research+Clinics+%28LRC%29+Prevalence+Study+%28PS%29&amp;acronym=LRC-PS</a>

**Data Source: Lung Health Study** (<https://biolincc.nhlbi.nih.gov/studies/LHS/>)

**Brief Description:** The purpose of the Lung Health Study (LHS) was to determine the effects of Special Care compared to Usual Care on rate of decline in pulmonary function in a group of cigarette smokers identified as having mild abnormalities in pulmonary function. In addition, the study sought to determine if participants with chronic obstructive pulmonary disease, who were assigned to inhaled corticosteroids, had a lower rate of decline in lung function and lower incidence of respiratory morbidity compared to participants assigned to placebo.

**Examination Components:** Demographics; respiratory function; hospitalizations.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Men and women cigarette smokers	Adults (35 years to 60 years)	White; non-White	Education; median area income; marital status; employment status	–	1984-2005	Yes, available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/LHS/">https://biolincc.nhlbi.nih.gov/studies/LHS/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lung+Health+Study+%28LHS%29&amp;acronym=LHS">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lung+Health+Study+%28LHS%29&amp;acronym=LHS</a>

**Data Source: Monitoring the Future Survey (<http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future>)**

**Brief Description:** Monitoring the Future (MTF) is a research program conducted at the University of Michigan’s Institute for Social Research under a series of investigator-initiated research grants from the National Institute on Drug Abuse (NIDA) of the National Institutes of Health (NIH). The study comprises several ongoing series of annual surveys of nationally representative samples of 8<sup>th</sup>- and 10<sup>th</sup>-grade students, 12<sup>th</sup>-grade students and high school graduates into adulthood. MTF is a source of information on trends in licit and illicit psychoactive drug use among American adolescents, college students and young adults nationwide. The survey is conducted by the University of Michigan’s Institute for Social Research, and data are collected using a self-administered questionnaire.

**Examination Components:** Two components: 1) core questions on demographics and drug use; 2) additional questions on attitudes toward religion, parental influences, changing roles of women, educational aspirations, self-esteem, exposure to sex and drug education, and violence and crime in and out of school.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescent students	8 <sup>th</sup> -, 10 <sup>th</sup> -, and 12 <sup>th</sup> -graders; college students; and young adults	Black; White; Hispanic <sup>20</sup>	Demographics on approximately 50,000 students in about 420 public and private secondary schools	Region of the country: Northeast, North Central, South, West (based on 2013 codebook)	1975-ongoing <sup>21</sup>	Public Use Files available here: <a href="http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/35">http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/35</a>	Regular press releases can be found here: <a href="http://monitoringthefuture.org/press.html">http://monitoringthefuture.org/press.html</a>

<sup>20</sup> From the 2013 codebook: How do you describe yourself? (Select one or more responses.) Black or African American; Mexican American or Chicano; Cuban American; Puerto Rican; Other Hispanic or Latino; Asian American; White (Caucasian); American Indian or Alaska Native; Native Hawaiian or Other Pacific Islander. Recoded in this dataset so that Black or African American = 1; White (Caucasian) = 2; Hispanic = 3 (Mexican... or Cuban... or Puerto Rican or Other Hispanic...). All other responses, including those of respondents who fell into more than one of the three categories, were deleted. 1 = Black or African American; 2 = White (Caucasian); 3 = Hispanic [see above].

<sup>21</sup> Data collection on high school seniors began in 1975; data collection on high school graduates began in 1976 (beginning with the class of 1976, a randomly selected sample from each senior class has been followed up biannually after high school on a continuing basis; these respondents receive a mail questionnaire at their home, which they complete and return to MTF), and data collection on 8<sup>th</sup>- and 10<sup>th</sup>-grade students began in 1991.

**Data Source: Multi-Ethnic Study of Atherosclerosis (<http://www.mesa-nhlbi.org/>)**

**Brief Description:** The Multi-Ethnic Study of Atherosclerosis (MESA) investigates the prevalence, correlates and progression of subclinical cardiovascular disease (CVD) and risk factors that predict progression to clinically overt CVD and that predict progression of subclinical disease itself, in a population-based sample of 6,800 ethnically diverse men and women.

**Examination Components:** Demographics; medical history; psychosocial questionnaires; laboratory assessments; coronary artery calcium; intima-medial thickness; spirometry.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Asymptomatic adult men and women from six field centers across the U.S.	Adults (45 years to 84 years)	White; Black; Asian (Chinese); Hispanic	Education; income; marital status; health insurance; employment status; occupation	U.S. community (note public data through the NHLBI data repository does not include geography)	2000-present (latest data from 2010-2011; each examination takes place over approximately two years)	Yes; available upon request, through the MESA Study at <a href="http://www.mesa-nhlbi.org/">http://www.mesa-nhlbi.org/</a> or through the NHLBI data repository at ( <a href="https://biolincc.nhlbi.nih.gov/studies/mesa/">https://biolincc.nhlbi.nih.gov/studies/mesa/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multi-Ethnic+Study+of+Atherosclerosis+%28MESA%29&amp;acronym=MESA">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multi-Ethnic+Study+of+Atherosclerosis+%28MESA%29&amp;acronym=MESA</a>

**Data Source: Multiple Risk Factor Intervention Trial (<https://biolincc.nhlbi.nih.gov/studies/mrfit/>)**

**Brief Description:** The Multiple Risk Factor Intervention Trial (MRFIT) sought to evaluate the effect of multiple risk factor intervention on mortality from coronary heart disease in high-risk men.

**Examination Components:** Demographics; physical exam; ECG; laboratory assessments; behavioral questionnaires; diet recall.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Men at high risk for coronary heart disease	Adults (35 years to 57 years)	White; Black; Oriental; Spanish American; American Indian; Other	Education; income; marital status; employment status; acculturation	–	1972-1998	Yes; available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/mrfit/">https://biolincc.nhlbi.nih.gov/studies/mrfit/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multiple+Risk+Factor+Intervention+Trial+for+the+Prevention+of+Coronary+Heart+Disease+%28MRFIT%29&amp;acronym=MRFIT">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multiple+Risk+Factor+Intervention+Trial+for+the+Prevention+of+Coronary+Heart+Disease+%28MRFIT%29&amp;acronym=MRFIT</a>

**Data Source: National Cooperative Inner City Asthma Study, Phase I**

([http://www.cdc.gov/asthma/interventions/inner\\_city\\_asthma\\_researchbase.htm](http://www.cdc.gov/asthma/interventions/inner_city_asthma_researchbase.htm))

**Brief Description:** Epidemiologists and clinical researchers have known for some time that the burden of asthma is especially great in urban areas with high levels of poverty and large minority populations. This is evidenced by the greater frequency of severe asthma episodes that lead to hospitalization or death. Before the mid-1990s, however, only a few interventions were designed or evaluated specifically for inner-city populations. Among those interventions, the impact has varied. The most promising results were reports of the decrease in emergency department use and hospitalization among children with the most severe asthma. Many asthma interventions for children benefited only this subgroup of children. Interventions that reduce health care, although economically important, are not always associated with a corresponding reduction in asthma symptoms or severity. Study was funded in the 1990's by the National Institute of Allergy and Infectious Diseases (NIAID). Contact for the study is currently CDC.

**Examination Components:** The asthma-related characteristics among these children as a group revealed the following:

- Children averaged 3-3.5 days of wheeze for each of four two-week recall periods
- Eighty-three percent had no hospitalizations during a one-year period; 3.6 percent had two or more
- Smoking occurred in 39 percent of the households
- Twenty-five percent of the children were reported to have been in a neonatal intensive care unit
- Ten percent were on a respirator at birth
- Eighteen percent had low birth weight (less than 5.5 pounds)
- Fifty-eight percent had a family history of asthma
- Seventeen percent used no asthma medications
- Forty-two percent of the children taking any asthma medication had only relief medications/beta-agonists
- Seventy-seven percent of children tested had at least one positive skin test to asthma-associated antigens; 47 percent had three or more
- Fifty-three percent had difficulty obtaining follow-up asthma care
- Asthma triggers
- Environmental controls
- Asthma physiology
- Strategies for problem solving
- Communicating with the child's physician; children's group sessions; education sessions for caretakers

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
It involved 1,528 inner-city English- or Spanish-speaking children 4-9 years of age in eight U.S. cities	Children ages 4-9 years old	Puerto Rican; Dominican; Mexican; South American; Central/Latin American; Other Hispanic; African American; West Indian; Caribbean Black; White (ethnic group specified); Asian (ethnic group specified); Mixed; Native American; and Other	Functional/health status; services utilization; services expenditure and financing; socioeconomic; age/gender; other demographic/ sociocultural; and behavioral	City (New York City, NY; Detroit, MI; St. Louis, MO; Bronx, NY; Baltimore, MD; Cleveland, OH; Washington, DC; and Chicago, IL)	November 1992/June 1994	Available publicly at: <a href="http://www.cdc.gov/asthma/interventions/inner_city_asthma_researchbase.htm">http://www.cdc.gov/asthma/interventions/inner_city_asthma_researchbase.htm</a>  Phase I of this multiyear project was a randomized controlled trial.  Status: This periodic (every 3 months over a one-year period) data collection is completed.	"Healthy People 2000" (Full Report: Stock No. 017-001-00474-0 or Summary Report: Stock No. 017-001-00473-1) through the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325 (telephone 202-783-3238).

**Data Source: National Cooperative Inner City Asthma Study, Phase II** (<http://www.niaid.nih.gov/topics/asthma/research/Pages/innerCity.aspx>)

**Brief Description:** The National Cooperative Inner City Asthma Study (NCICAS), Phase II, is an intervention study aimed at reducing the asthma morbidity of inner-city children aged 5-11 years. There are a total of 540 intervention and 540 control group children across eight Asthma Study Units in eight centers. The intervention consists of a specially trained social worker called an Asthma Counselor (AC) who runs group and individual sessions with the intervention families. The baseline assessments were completed August-October 1994. The core intervention ran from November-December 1994, and a year of follow-up (including more intervention) continued through December 1995. A second follow-up (without more intervention) continued through December 1996. Process evaluation data are collected by the AC, including attendance at sessions and topics and problems discussed. Evaluation phone calls are being conducted at two-month intervals to measure the success of the intervention. These calls include questions about health care utilization and morbidity. The goal of ICAS from 1996 to 2001 is to design and conduct an environmental intervention study to reduce the exposure of children with asthma to house dust mites, secondhand smoke, cockroaches, pets, rodents and mold. The study showed that reducing environmental allergens, especially in the bedroom, resulted in a significant reduction in asthma morbidity in at-risk children.

**Examination Components:** Two clinical trials initiated during Phase I of ICAS have yielded important results and insights. In the Asthma Control Evaluation study, investigators divided 500 inner-city adolescents with asthma into two groups. One group received treatment based solely on clinical guidelines of asthma management, while the treatment of the other group was based on the clinical guidelines plus the measurement of exhaled nitric oxide, which is a biomarker of lung inflammation. In the latter group, asthma treatment was modified based on whether the nitric oxide level was high or low. After the year-long study, investigators demonstrated that the addition of a biomarker to modify guidelines-based therapy did not improve management. However, the results of the study clearly demonstrated that asthma, even in inner-city populations, can be well controlled using current asthma treatment guidelines.<sup>22</sup>

In the Inner City Anti-IgE Therapy for Asthma (ICATA) trial, investigators followed 419 inner-city children and adolescents with moderate to severe allergic asthma who were receiving NIH guidelines-based asthma therapy to control their disease. Half of the participants received omalizumab, a monoclonal antibody that targets the antibody immunoglobulin E (IgE), and the other half received a placebo. After a 60-week period, omalizumab plus guidelines-based therapy improved asthma control more than just guidelines-based therapy. The fall and spring increases in asthma attacks seen in the

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<sup>22</sup> Szeffler SJ, Mitchell H, Sorkness CA, Gergen PJ, O'Connor GT, Morgan WJ, Kattan M, Pongracic JA, Teach SJ, Bloomberg GR, Eggleston PA, Gruchalla RS, Kercksmar CM, Liu AH, Wildfire JJ, Curry MD, Busse WW. Management of asthma based on exhaled nitric oxide in addition to guideline-based treatment for inner-city adolescents and young adults: a randomised controlled trial. *Lancet*. 372(9643):1065-72 (2008).

participants receiving the placebo were almost eliminated in those participants receiving omalizumab. Participants who were both sensitized and exposed to cockroach allergen especially benefited from this intervention.<sup>23</sup>

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Aimed at reducing the asthma morbidity of inner-city children aged 5-11 years; there are a total of 540 intervention and 540 control group children across eight Asthma Study Units in eight centers and eight U.S. cities	Children ages 5-12 years old	Black or African American; White; Hispanic or Latino (of any race); Native American	Services utilization; services expenditure and financing; socioeconomic; gender; other demographic/ sociocultural and behavioral characteristics	City: New York City, NY; Detroit, MI; St. Louis, MO; Bronx, NY; Baltimore, MD; Cleveland, OH; Washington, DC; and Chicago, IL	August 1994/December 1996 (ongoing); this periodic (every two months over a two-year period) data collection is completed	Available publicly at: <a href="http://www.niaid.nih.gov/topics/asthma/research/Pages/innerCity.aspx#nicas">http://www.niaid.nih.gov/topics/asthma/research/Pages/innerCity.aspx#nicas</a>	Healthy People 2000 (Full Report: Stock No. 017-001-00474-0 or Summary Report: Stock No. 017-001-00473-1) through the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325 (telephone: 202-783-3238)

<sup>23</sup> Busse WW, Morgan WJ, Gergen PJ, Mitchell HE, Gern JE, Liu AH, Gruchalla RS, Kattan M, Teach SJ, Pongracic JA, Chmiel JF, Steinbach SF, Calatroni A, Togias A, Thompson KM, Szefer SJ, Sorkness CA. Randomized trial of omalizumab (anti-IgE) for asthma in inner-city children. *N Engl J Med.* 364(11):1005-15 (2011).

**Data Source:** National Epidemiologic Survey on Alcohol and Related Conditions (<http://pubs.niaaa.nih.gov/publications/AA70/AA70.htm>)

**Brief Description:** The National Institute on Alcohol Abuse and Alcoholism (NIAAA) began conducting the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) in 2001. To date, this is the largest survey ever conducted.

**Examination Components:** Rich dataset that captures a nationally representative sample on alcohol and related conditions. NESARC-III: non institutionalized population, 18 years and older, living in the contiguous United States and Alaska and Hawaii.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults	Adults, ages 18+	Black or African American; White, Hispanic or Latino (of any race); Native American; Asian or Pacific Islander	Education, occupation, income <sup>24</sup>	County	First wave: 2001-2002 Second wave: 2004-2005 Third wave: 2011-2012	Yes, available upon agreement of terms at <a href="http://www.niaaa.nih.gov/research/nesarc-iii/nesarc-iii-data-access">http://www.niaaa.nih.gov/research/nesarc-iii/nesarc-iii-data-access</a>	Summary of selected findings available at <a href="http://pubs.niaaa.nih.gov/publications/AA70/AA70.htm">http://pubs.niaaa.nih.gov/publications/AA70/AA70.htm</a>

<sup>24</sup> Other variables: traditional households, military personnel living off base, boarding or rooming houses, college quarters.

**Data Source: National Growth and Health Study** (<https://biolincc.nhlbi.nih.gov/studies/nghs/>)

**Brief Description:** The National Heart, Lung and Blood Institute (NHLBI) Growth and Health Study (NGHS) was an observational study initiated in 1985 by NHLBI. The purpose was to examine factors associated with the development of obesity and related cardiovascular disease risk factors in a cohort of 1,213 African American and 1,166 white girls. The NHLBI National Growth and Health Study recruited girls ages 9 and 10 years in two communities (Richmond, CA and Cincinnati, OH) and also from families enrolled in a health maintenance organization in the Washington, DC area. A total of 2,379 girls were enrolled in the study between 1987 and 1988 and were followed for nine years. Slightly more than half of the cohort was African American. Annual visits were conducted from 9 to 10 years of age through 18 to 19 years of age. Clinical assessments included anthropometric measures, blood pressure and stage of pubertal maturation. The factors studied included diet, physical activity, socioeconomic status, and familial and psychosocial influences. Risk factors measured included body weight, cigarette smoking, blood lipids and blood pressure. The goal was to investigate racial differences in dietary, physical activity, family and psychosocial factors associated with the development of obesity from pre-adolescence through maturation between African American and white girls. Secondly, the NGHS sought to examine the effects of obesity on cardiovascular disease risk factors.

Some of the main findings were that the largest accrual of body fat occurred around the onsets of puberty and menarche. After age 12, African American girls were significantly more overweight or obese than white girls. Earlier menarche was found to confer an additional risk for greater gain in adiposity in both white and African American girls. These results indicate that significant race-ethnic divergence in adiposity occurred during early adolescence.

**Examination Components:** Self-assessment. Subjects had annual examinations, and data collected included physical examination, anthropometric measurements, dietary information including food pattern and nutrient intake; physical activity; lipid, lipoprotein, and apolipoprotein profiles; family socioeconomic status; and psychosocial information.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children with obesity and cardiovascular risk factors	Girls ages 9 and 10 years old	Black or African American; White	The study recruited girls 9 and 10 years of age in two communities (Richmond, CA and Cincinnati, OH) and also from families enrolled in a health maintenance organization in the Washington, D.C. area. A total of 2,379 girls were enrolled in the study between 1987 and 1988 and were followed for 9 years. Slightly more than half of the cohort was African-American.	City; three field centers, located in San Francisco, Cincinnati, and Washington, DC, and a central data coordinating center were funded.	1985-2000	Data available upon request through NHLBI Data repository (BioLINCC: <a href="https://biolincc.nhlbi.nih.gov/studies/nghs/">https://biolincc.nhlbi.nih.gov/studies/nghs/</a> )	White House Task Force on Childhood Obesity Report to the President: <a href="http://www.letsmove.gov/white-house-task-force-childhood-obesity-report-president">http://www.letsmove.gov/white-house-task-force-childhood-obesity-report-president</a>  Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=NHLBI+Growth+and+Health+Study+%28NGHS%29&amp;acronym=NGHS">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=NHLBI+Growth+and+Health+Study+%28NGHS%29&amp;acronym=NGHS</a>

**Data Source: National Longitudinal Mortality Study** (<https://biolincc.nhlbi.nih.gov/studies/nlms/> and <http://www.census.gov/nlms>)

**Brief Description:** The National Longitudinal Mortality Study (NLMS) is a prospective epidemiologic study of a national sample of the United States population, focusing on the socioeconomic status and mortality of 1.3 million persons. The baseline data consists of Current Population Samples which were matched to the National Death Index for assessment of mortality. Many socioeconomic variables for analysis of cofactors related to mortality. Other sponsoring agencies are the National Heart, Lung and Blood Institute; the National Institute on Aging; and the National Center for Health Statistics (NCHS). Expected to add data on 60,000 cancer deaths, this linkage will allow an in-depth analysis of racial/ethnic, socioeconomic and occupational differentials in cancer mortality for the major cancer sites. An important NLMS milestone was achieved in mid-June of 2001 with the completion of the match of approximately 2.4 million NLMS records to the National Death Index under secured conditions. The successful completion of this match marks the beginning of the approximately one-year processing effort necessary to identify and verify the match and update NLMS records with valid mortality follow-up information. Slightly more than 160,000 additional cases of mortality are expected to be added to the NLMS mortality count, giving a total of approximately 260,000 deaths out of the 2.4 million NLMS records. The mortality follow-up period for these data is from 1979 to 1998. Research projects built on NLMS include a database containing smoking information collected in the 1990s that includes 173,704 records with valid responses to "smoking" questions, which will be linked to the NLMS mortality data.

**Examination Components:** Data are available for analysis without identifiers. Data are limited only to civilian, noninstitutionalized population of the U.S. Reliable mortality information may not be obtainable for small geographic areas. Census data are linked to mortality information obtained from death certificates available for deceased persons through the NCHS, CDC.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
National sample of U.S. population	Infants/toddlers; children; youth (early teens to 18 years old); young adults (18 years to 24); adults (25 years to 64); and older adults (65 years and older; top coded at 90)	White; Black; American Indian or Eskimo; Asian or Pacific Islander; Other non-White; Hispanic Origin: Mexican, Other Hispanics, non-Hispanics	Census Current Population Surveys (CPS) are matched to mortality information from death certificates available for deceased persons through NCHS. Extensive demographic, social, economic, and occupation information is collected in the CPS. The study currently consists of approximately 2.3 million records with over 250,000 identified mortality cases.	National	1973-2011	Available publicly upon request at: <a href="http://www.census.gov/did/www/nlms/publications/public.html">http://www.census.gov/did/www/nlms/publications/public.html</a>  Based on frequencies provided for each file (for years 1979 through 2002) in the public use data file reference manual, there are 11,099 American Indians/Alaska Natives (AI/AN) and 23,735 Asians/Other Pacific Islanders (A/PI) in this file. Data are available for major census racial/ethnic groups, such as Whites, Blacks/African Americans, American Indians/Alaska Natives, Asian/Pacific Islanders, Mexicans, Puerto Ricans, Cubans, Central and South Americans, and other Hispanics.	The NLMS website provides a list of published articles based all or in part on either the full NLMS database or the NLMS Public Use File. The URL for this bibliography is: <a href="http://www.census.gov/nlms/bibliography.html">http://www.census.gov/nlms/bibliography.html</a>

**Data Source: National Longitudinal Study of Adolescent to Adult Health (<http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/21600>)**

**Brief Description:** The National Longitudinal Study of Adolescent Health (AddHealth) is a longitudinal study of a nationally representative sample of adolescents in grades 7-12 in the United States during the 1994-95 school year. The Add Health cohort has been followed into young adulthood with four in-home interviews, the most recent in 2008, when the sample was aged 24-32. AddHealth combines longitudinal survey data on respondents' social, economic, psychological and physical well-being with contextual data on the family, neighborhood, community, school, friendships, peer groups and romantic relationships. This provides unique opportunities to study how social environments and behaviors in adolescence are linked to health and achievement outcomes in young adulthood. The fourth wave of interviews expanded the collection of biological data in AddHealth to understand the social, behavioral and biological linkages in health trajectories as the AddHealth cohort ages through adulthood.

**Examination Components:** Longitudinal, multilevel design with independent measurement at the individual, family, peer group, school and community levels.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescents (followed into young adulthood) <sup>25</sup>	Adolescents grades 7-12 (at entry)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Household income; personal earnings; home ownership; debt; public assistance	National, State; county; tract; and block group levels (provided separately, in contextual data)	First wave: 1995 Second wave: 1996 Third wave: 2001-2002 Fourth wave: 2007-2008 Fifth wave: 2015-2018	Yes, Public Use Datasets can be found here: <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/21600">http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/21600</a> .  A CD-ROM is available for purchase from Sociometrics, and special arrangements may be made with the principal investigator for other data access needs. Additional sets can also be found at: <a href="http://www.cpc.unc.edu/projects/addhealth/data">http://www.cpc.unc.edu/projects/addhealth/data</a>	Study publications are available at <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/bibliography/studies/21600/resources?collection=DATA&amp;archive=ICPSR&amp;sortBy=1">http://www.icpsr.umich.edu/icpsrweb/ICPSR/bibliography/studies/21600/resources?collection=DATA&amp;archive=ICPSR&amp;sortBy=1</a>

<sup>25</sup> Data have been collected from adolescents, their fellow students, school administrators, parents, siblings, friends and romantic partners through multiple data collection components, including four respondent in-home interviews.

**Data Source: National Long Term Care Survey (<http://www.nltcs.aas.duke.edu/>)**

**Brief Description:** The 1982, 1984, 1989, 1994, 1999 and 2004 National Long Term Care Surveys (NLTCs) are surveys of the entire aged population with a particular emphasis on the functionally impaired. The surveys are designed to measure the point prevalence of chronic (90 days or more) disability in the United States elderly Medicare-enrolled population and changes (both improvement and incidence) in chronic disability (and institutionalization) over time. Because the samples are drawn from Medicare beneficiary enrollment files, they are considered nationally representative of both community and institutional residents. The current dataset contains a sample of 35,789 people. NLTCs sample persons are followed until death and are permanently and continuously linked to the Medicare record system from which they are drawn. Virtually 100 percent of cases can be longitudinally tracked so that changes in disability may be identified, as well as exact dates of death, detailed Medicare expenditures and types of service use. An oversample of the very old (ages 95+) was included in 1984 (N=540) and in 1999 (N=600). Next-of-kin mortality follow-up was conducted in 1984 and again in 2000 to obtain retrospective information over the prior two- to four-year period about deceased subjects. Funding constraints precluded conducting the mortality follow-up after every wave.

The collection of blood and buccal cell samples—using cases from the 1999 NLTCs—began on October 16, 2000, and made it possible to examine national distributions of the prevalence of particular genes predisposing to major chronic conditions, such as numerous APOE alleles (which relate to Alzheimer’s and cardiovascular disease, and maybe fundamental longevity), the Werner Syndrome gene (which is a marker for premature aging) and the ACE (which controls blood pressure and renal function) and P53 (apoptosis genes). There is a total of about 3,700 bloods and 4,000 buccal wash specimens in the final dataset, allowing analyses of some infrequent genes.

The survey is administered by the U.S. Census Bureau using trained interviewers, and the response rate is above 95 percent for all waves. RACE\_DET (Missing, White, Black, Asian/Pacific Islander, American Indian/Eskimo, Aleutian/Other); RACE\_WBO (White, Black, Other).

**Examination Components:** The surveys provide nationally representative data on the prevalence and patterns of both physical and cognitive functional limitations, medical conditions, recent medical problems and health care services used; longitudinal and cohort patterns of change in functional limitation and mortality over 17 years; the kind and amount of formal and informal services received by impaired individuals and how they are paid; demographic and economic characteristics like age, race, sex, marital status, education, income and assets; out-of-pocket expenditures for health care services and other sources of payment; housing; and neighborhood characteristics. Samples are drawn from Medicare beneficiary enrollment files, and they are considered nationally representative of both community and institutional residents. The NLTCs survey population consists of a sample of 35,789 people drawn from national Medicare enrollment files in 1982 that has been augmented with subsequent samples of approximately 20,000 Medicare enrollees obtained by adding 5,000 people passing age 65 between successive surveys conducted approximately every five years. This technique ensures a large, nationally-representative sample at each point in time. Both elderly in the community (including those not impaired) and

those residing in institutions are represented in the samples .The survey is administered by the Census Bureau using trained interviewers, and the response rate is above 95 percent for all waves.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults (65 years or older)	Age 65 years and older (Medicare recipients)	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Family income; welfare status; value of home; amount paid in rent; education; marital status	National	1982-2004	Yes, available upon registration at: <a href="http://www.nlts.aas.duke.edu/availabledata.htm">http://www.nlts.aas.duke.edu/availabledata.htm</a> or <a href="http://www.icpsr.umich.edu/icpsrweb/NACDA/studies/9681?classification=CD-ROM.I.*&amp;archive=NACDA#datasetsSection">http://www.icpsr.umich.edu/icpsrweb/NACDA/studies/9681?classification=CD-ROM.I.*&amp;archive=NACDA#datasetsSection</a>	Study publications are available at <a href="http://www.icpsr.umich.edu/icpsrweb/NACDA/biblio/studies/9681/resources?collection=DATA&amp;archive=ICPSR&amp;sortBy=1">http://www.icpsr.umich.edu/icpsrweb/NACDA/biblio/studies/9681/resources?collection=DATA&amp;archive=ICPSR&amp;sortBy=1</a>

**Data Source: National Survey of Adolescent Males** (<https://sites.google.com/site/cahjhsp/national-survey-of-adolescent-males>)

**Brief Description:** The National Survey of Adolescent Males (NSAM) was implemented in four waves—1988, 1990-91, 1995 and 2007. The survey was designed to increase knowledge and understanding of the determinants of adolescent male contraceptive use, sexual activity and related risk behaviors. The NSAM examines factors affecting young men’s (and their partners’) risk of becoming infected with HIV or other sexually transmitted diseases or of becoming a parent.

**Examination Components:** Longitudinal, face-to-face interviews. The most sensitive topics (e.g., substance use, risky sexual behaviors) were assessed with confidential, written, self-administered questionnaires. Extensive personal histories of sexual activity and contraception use were gathered, as well as respondents’ personal perceptions of the various costs and benefits of contraceptive use and fathering children. Information on school attendance

and recent employment history were additionally included. Wave 2, which is also referred to as the Follow-up Survey of Young Men, was conducted between November 1990 and March 1991, when respondents were generally between the ages of 17 and 22. Of those respondents who participated in Wave 1, the follow-up rate was 89 percent (N=1,676). Data collection procedures were similar to those employed in Wave 1, with the use of face-to-face interviews and self-administered questionnaires. A total of 1,816 variables were assessed across 1,880 cases in Waves 1 and 2.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescent males	Adolescent males (15-19 years old)	Black or African American; White; Hispanic or Latino (of any race)	Old Cohort - nationally representative multistage stratified probability sample, never-married males who were 15 to 19 years old in 1988. Oversampled Black and Hispanic males.	National	1988; 1990-1991; 1995; 2007	Data are available for purchase from the Sociometrics Corporation ( <a href="http://www.socio.com">http://www.socio.com</a> ), or by calling 1-800-846-DISK.	Study publications available at <a href="https://sites.google.com/site/cahjhsph/national-survey-of-adolescent-males">https://sites.google.com/site/cahjhsph/national-survey-of-adolescent-males</a>

**Data Source:** National Survey on Energy Balance-Related Care Among Primary Care Physicians (<http://appliedresearch.cancer.gov/surveys/energy/>)

**Brief Description:** The National Survey of Energy Balance-Related Care Among Primary Care Physicians is designed to obtain current, nationally representative data on primary care physicians’ characteristics, knowledge, attitudes and practices related to services for diet, physical activity and weight control. The goal is to develop a national baseline on the use of energy balance risk assessment, counseling and referral services in physician practice, and to identify the characteristics of physicians who routinely incorporate these activities in patient care. Physicians surveyed consisted of those who treat both adults and children, including internists, family physicians, obstetricians/gynecologists and pediatricians. Separate questionnaires were used to address knowledge, attitudes and behaviors of energy balance-related care in physicians who treat adults and those who treat children. An administrative questionnaire was used to address practice and health system-level characteristics. The National Cancer Institute (NCI) fielded the survey instruments in 2008.

**Examination Components:** Three questionnaires: knowledge, attitudes and behaviors of energy balance-related care (1) in physicians who treat adults; (2) in physicians who treat children; and (3) practice and health system-level characteristics.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Primary care physicians (including internists, family physicians, obstetricians/ gynecologists, and pediatricians)	–	–	Patient population-level demographics (as reported by the physician)	National	2008	No, but the physician questionnaires and related publications are posted on the website.	Publications available online and added periodically at <a href="http://appliedresearch.cancer.gov/cgi-bin-pubsearch/pubsearch/index.pl?initiative=EBAL">http://appliedresearch.cancer.gov/cgi-bin-pubsearch/pubsearch/index.pl?initiative=EBAL</a>

**Data Source: Puerto Rico Heart Health Program** (<https://biolincc.nhlbi.nih.gov/studies/prhhp/>)

**Brief Description:** The Puerto Rico Heart Health Program (PRHHP) is a prospective epidemiologic study of cardiovascular disease conducted in rural and urban areas of Puerto Rico. There were 9,824 men who participated in four cardiovascular examinations and with 12 years of follow-up.

**Examination Components:** To investigate morbidity and mortality from coronary heart disease (CHD) in Puerto Rican rural and urban men. The objectives of the study were: (1) to identify factors related to the development of CHD; (2) compare the etiology of disease in rural versus urban men; and (3) determine the prevalence and incidence of CHD and other cardiovascular diseases in Puerto Rican males. The examination consisted of standardized questionnaires to determine education, occupation, smoking habits and physical activity. Trained interviewers conducted a nutritional survey through a 24-hour diet recall. Subjects were also examined to determine prevalent cardiovascular, cerebrovascular and peripheral vascular abnormalities. The examination included vital capacity, a 12-lead electrocardiogram (ECG), and laboratory tests for hematocrit, glucose, serum cholesterol, serum glycerides and lipoprotein electrophoresis. A medical history was also obtained. Three additional exams, approximately three years apart, were conducted and morbidity and mortality follow-up concluded in 1980.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All participants were of Hispanic origin; a total of 9,824 (2,976 rural; 6,848 urban) men, age 45 to 64, were examined at the baseline exam	Men ages 45-64 years old	Hispanic or Latino (any race)	Education; income; occupation <sup>26</sup>	State	1965-1980	Data available upon request through the National Heart, Lung and Blood Institute (NHLBI) Data repository (BioLINCC: <a href="https://biolincc.nhlbi.nih.gov/studies/prhhp/">https://biolincc.nhlbi.nih.gov/studies/prhhp/</a> )	Study publications available at <a href="https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Puerto+Rico+Heart+Health+Program+%28PRHHP%29&amp;acronym=PRHHP">https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Puerto+Rico+Heart+Health+Program+%28PRHHP%29&amp;acronym=PRHHP</a>

<sup>26</sup> As Puerto Rico became more industrialized in the 1940s and 1950s, mortality rates for CHD increased. Since many factors related to CHD can be relatively homogenous within a population, two contrasting subgroups were selected for study in Puerto Rico: a rural population of men from a mountainous community and an urban population selected from San Juan. The NHLBI initiated the Puerto Rico Heart Health Program in May, 1965, as a prospective study of lifestyle, environmental and biological factors in the progression of cardiovascular disease in Puerto Rican men.

**Data Source: Registry and Surveillance of Hemoglobinopathies** (<http://www.cdc.gov/ncbddd/hemoglobinopathies/rush.html>)

**Brief Description:** The Registry and Surveillance of Hemoglobinopathies (RuSH), a four-year pilot project, was funded in 2010 in seven states to collect data on people diagnosed with a family of inherited blood disorders and hemoglobinopathies, such as sickle cell disease (SCD) and thalassemia. The National Heart, Lung and Blood Institute (NHLBI) and CDC have implemented a new surveillance system to determine the number of patients diagnosed with hemoglobinopathies (including SCD, thalassemias and hemoglobin E disease). The contact organization is CDC.

**Examination Components:** Designed to assess the possibility of developing a national surveillance system to collect information about people with SCD and thalassemia, and to develop health education materials to increase knowledge and awareness.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients diagnosed with a family of inherited blood disorders known as hemoglobinopathies, including sickle cell disease, thalassemias and hemoglobin E disease	All	All, but primarily African Americans	–	State (seven states funded for data collection: California, Florida, Georgia, Michigan, North Carolina, Pennsylvania and New York)	Launched in 2010; four years of pilot project-2013	–	Available at <a href="http://www.cdc.gov/ncbddd/sicklecell/freematerials.html">http://www.cdc.gov/ncbddd/sicklecell/freematerials.html</a> or <a href="http://www.cdc.gov/ncbddd/hemoglobinopathies/documents/rush-strategies_508.pdf">http://www.cdc.gov/ncbddd/hemoglobinopathies/documents/rush-strategies_508.pdf</a>  Research findings based on data from disease registries may provide new ideas for drug therapies and can spur the development of tests that can determine severity of diseases over the lifespan.

**Data Source: State Cancer Profiles (<http://statecancerprofiles.cancer.gov>)**

**Brief Description:** The objective of the State Cancer Profiles website is to provide a system to characterize the cancer burden in a standardized manner in order to motivate action, integrate surveillance into cancer-control planning, characterize areas and demographic groups and expose health disparities. The focus is on cancer sites for which there are evidence-based control interventions. Interactive graphics and maps provide visual support for deciding where to focus cancer control efforts. This resource is a compilation of other databases, bringing together data that are collected from public health surveillance systems by using either their published reports or Public Use Files.

**Examination Components:** Cancer mortality; incidence; trend comparisons; demographics; screening rates; risk factors.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	Adults 18 years and older	Census categories for race/ethnicity	Crowding; education; income; insurance; mobility, non-English language; poverty; employment	State level and county level	1975-present	Available online; provides quick and easy access to descriptive cancer statistics in order to prioritize investments in cancer control .Epidemiologists may find the site useful for exploring cancer statistics to identify research opportunities.	Data synthesis reports are posted every few months on the "Site History" link as they are released to the public at <a href="http://statecancerprofiles.cancer.gov/about/">http://statecancerprofiles.cancer.gov/about/</a>  The site provides prepared reports, graphs, maps and interactive tools .Users can also prepare their own tailored reports, available at <a href="http://statecancerprofiles.cancer.gov/">http://statecancerprofiles.cancer.gov/</a>

**Data Source:** Treatment of Depression Collaborative Research Program (<http://www.ncbi.nlm.nih.gov/pubmed/2684085>)

**Brief Description:** The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) was a collaborative agreement between NIMH (Mood, Anxiety and Personality Disorder Research Branch) and three research sites—George Washington University, University of Oklahoma and the University of Pittsburgh. The Data Management and Analysis Facility for the study was the Department of Veterans Affairs Cooperative Studies Program Coordinating Center at the Perry Point Veterans Affairs Medical Center. NIMH TDCRP was the first coordinated study initiated by the NIMH in the field of psychotherapy. The study had two major aims: 1) to test the feasibility and value of the collaborative clinical trial model in the area of psychotherapy research and 2) to study, within this research model, the effectiveness of two specific forms of psychotherapy for treating non-bipolar, non-psychotic depressed outpatients.

**Examination Components:** There were 239 patients in the study.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Mental health outpatients	–	Race and ethnicity were asked for mother, father, patient, and spouse as being White or Other, which was to be specified	Education; occupation; and income were collected	National	Before 1989 (article published in 1989)	Computer tapes (Accession Number PB94-501806GEI from the National Technical Information Service (703-487-4650)	Study publication available at <a href="http://www.ncbi.nlm.nih.gov/pubmed/2684085">http://www.ncbi.nlm.nih.gov/pubmed/2684085</a>

**Data Source:** Trials of Hypertension Prevention, Phases I and II (<https://biolincc.nhlbi.nih.gov/studies/tohp/>)

**Brief Description:** Phase I of the Trials of Hypertension Prevention (TOHP I) was designed to test the short-term feasibility and efficacy of seven nonpharmacologic interventions in persons with high normal blood pressure (BP). These interventions included the lifestyle interventions of weight loss, sodium reduction and stress management, and the nutritional supplement interventions of calcium, magnesium, and potassium and fish oil. Phase II (TOHP II) was designed to test the efficacy of interventions to promote weight loss, sodium reduction and the combination of weight loss and sodium reduction in decreasing diastolic BP, systolic BP and the incidence of hypertension during a three- to four-year follow-up period in moderately overweight men and women with a high-normal level of diastolic BP.

**Examination Components:** Demographics; medical history; physical exam; diet recall; laboratory assessments.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Phase I: Persons with high-normal BP Phase II: Moderately overweight men and women with high-normal diastolic blood pressure	Adults (30 years to 54 years)	White; Hispanic, Black; Asian; Other	Education; marital status; employment status; occupation	—	1986-1998	Yes, available upon request through the NHLBI data repository: ( <a href="https://biolincc.nhlbi.nih.gov/studies/tohp/">https://biolincc.nhlbi.nih.gov/studies/tohp/</a> )	List of publications available at <a href="https://www.clinicaltrials.gov/ct/show/NCT0000528?order=1">https://www.clinicaltrials.gov/ct/show/NCT0000528?order=1</a>

<https://www.clinicaltrials.gov/ct/show/NCT0000528?order=1>

**Data Source: U.S. Renal Data System (<http://www.usrds.org>)**

**Brief Description:** The U.S. Renal Data System (USRDS) is a national data system that collects, analyzes and distributes information about end-stage renal disease (ESRD) in the United States.

**Examination Components:** USRDS staff collaborates with members of CMS, the United Network for Organ Sharing, and the ESRD networks, sharing datasets and actively working to improve the accuracy of ESRD patient information. The data used by the USRDS Coordinating Center originates from CMS, the Organ Procurement and Transplantation Network, CDC, the ESRD Networks, the USRDS Special Studies and the U.S. Census Bureau.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
People with ESRD	Adults 20-39 years old; 40-59 years old; 60 years and older	Black or African American; White; Other	ESRD incidence, prevalence, patient demographics/ characteristics and treatment modalities; data regarding clinical indicators and preventive care, hospitalization, survival and costs	National, state and county level data available via online query system (RenDER: <a href="http://www.usrds.org/render/xrender_home.asp">http://www.usrds.org/render/xrender_home.asp</a> )	1994-present	Online data, query system: ( <a href="http://www.usrds.org/render/xrender_home.asp">http://www.usrds.org/render/xrender_home.asp</a> ) and researcher's guide; database is available with approved research protocols: ( <a href="http://www.usrds.org/request.aspx">http://www.usrds.org/request.aspx</a> )	Annual data report (archived since 1994) available at: <a href="http://www.usrds.org/adr.aspx">http://www.usrds.org/adr.aspx</a> ) and quarterly updates: ( <a href="http://www.usrds.org/qtr/default.aspx">http://www.usrds.org/qtr/default.aspx</a> )

**Data Source: Surveillance, Epidemiology, and End Results Program Registries (<http://seer.cancer.gov>)**

**Brief Description:** The Surveillance, Epidemiology, and End Results (SEER) of the National Cancer Institute (NCI) is an authoritative source of information on cancer incidence and survival in the United States. SEER currently collects and publishes cancer incidence and survival data from population-based cancer registries covering approximately 30 percent of the U.S. population. SEER coverage includes 26 percent of African Americans, 38 percent of Hispanics, 44 percent of American Indians and Alaska Natives, 50 percent of Asians, and 67 percent of Hawaiian/Pacific Islanders.

**Examination Components:** The SEER Program registries routinely collect data on patient demographics, primary tumor site, tumor morphology and stage at diagnosis, first course of treatment and follow-up for vital status. The SEER Program is the only comprehensive source of population-based information in the U.S. that includes stage of cancer at the time of diagnosis and patient survival data.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All	White; Black; Hispanic; American Indian/Alaska Native; Asian; Native Hawaiian/Pacific Islander; Other Race; Two or More Races; Chinese; Filipino; Japanese	Demographics, socioeconomic and other variables	County	1973-present	A signed data agreement form is required to access the SEER data: ( <a href="http://seer.cancer.gov/data/access.html">http://seer.cancer.gov/data/access.html</a> ) SEER research data files and software are available to download or via discs shipped directly.	Annual Report available at <a href="http://seer.cancer.gov/report_to_nation/">http://seer.cancer.gov/report_to_nation/</a> <a href="http://seer.cancer.gov/report_to_nation/">http://seer.cancer.gov/report_to_nation/</a> Updated annually and provided in print and electronic formats at <a href="http://seer.cancer.gov/report_to_nation/archive.html">http://seer.cancer.gov/report_to_nation/archive.html</a>

**Data Source:** National Longitudinal Alcohol Epidemiologic Survey (<https://research.archives.gov/id/598151>)

**Brief Description:** Face-to-face interviews were conducted by the U.S. Census Bureau. The National Longitudinal Alcohol Epidemiologic Survey (NLAES) can produce estimates for the coterminous U.S. and for the four census regions (excluding Alaska and Hawaii from the West region). The survey was designed to provide comprehensive information on amounts and patterns of alcohol consumption and on problems associated with alcohol. It is the only nationally representative survey that uses current DSM-IV psychiatric criteria for classifying alcohol use disorders (i.e. alcohol abuse and dependence). It also includes data on age of drinking onset, exposure to alcohol treatment, family history of alcoholism, major depressive disorder, smoking and the presence of major depressive disorders. Data for Wave 1 were collected in 1992. At present, there are no plans for a follow-up of this sample.

**Examination Components:** Household surveys of 42,862 persons; face-to-face interviews; data on age of drinking onset.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The NLAES 18 years and older in the coterminous U.S.; the sampling plan included oversampling of Black respondents and respondents from 18 to 29 years of age	Adults 18 years and older	Black or African American; White; Hispanic or Latino (of any race); American Indian/Alaska Native; Asian/Pacific Islander; Other	Education; marital status and history; employment status; occupation; industry; household income; family income; health insurance; retirement or disability pension; and supplemental income from savings; investments; or government financial assistance programs	National	1991-1992	Yes - public use dataset is available from Cornell University, Cornell Institute for Social and Economic Research  Catalog files available at <a href="https://catalog.archives.gov/id/598151">https://catalog.archives.gov/id/598151</a>	Findings from the 1992 survey available at <a href="http://pubs.niaaa.nih.gov/publications/NLAESdrm.pdf">http://pubs.niaaa.nih.gov/publications/NLAESdrm.pdf</a>

**Data Source:** Women’s Health Initiative Observational Study (<http://www.nhlbi.nih.gov/whi/>)

**Brief Description:** The Women’s Health Initiative Observational Study (WHI-OS) examines the relationship between lifestyle, socioeconomic, health and other risk factors with cardiovascular, breast cancer, colorectal cancer and osteoporotic fracture outcomes.

**Examination Components:** Demographics, medical history, family history, behavioral questionnaires. Secondary objectives include providing more reliable estimates of the extent to which known risk factors predict disease, more precise estimates of new occurrences of disease and to provide a future resource for the identification of new or novel risk factors, especially factors found in blood.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Post-menopausal women	Adult women ages 49 to 81 years	White; Black, African American, or Negro; American Indian or Alaska Native; Spanish/Hispanic/Latino; Asian Indian; Chinese; Filipino; Japanese; Korean; Other Asian or Vietnamese; Native Hawaiian; Other Pacific Islander, Guamanian, Chamorro, or Samoan; Some Other Race	Education; income; marital status; health insurance; employment status; occupation	U.S. community (note public data through the NHLBI data repository includes only census geographic division)	1991-present	Yes; available upon request through the WHI Study or through the NHLBI data repository ( <a href="https://biolincc.nhlbi.nih.gov/studies/whios/">https://biolincc.nhlbi.nih.gov/studies/whios/</a> )	Summary of key findings and publications available at <a href="https://www.nhlbi.nih.gov/whi/">https://www.nhlbi.nih.gov/whi/</a>



## Department of Health and Human Services Substance Abuse and Mental Health Services Administration



**Data Source: National Survey on Drug Use and Health (<http://www.icpsr.umich.edu/icpsrweb/content/SAMHDA/help/nsduh-chart.html>)**

**Brief Description:** The National Survey on Drug Use and Health (NSDUH) is the primary source of statistical information on the use of illegal drugs, alcohol and tobacco in the United States. NSDUH is conducted annually and collects information from residents of households and noninstitutional group quarters. NSDUH provides information on the incidence and prevalence of substance use in the population and the problems associated with use. The survey collects information on sociodemographic characteristics, perceptions of risk and availability and mental health issues. Prior to 2002, the survey was called the National Household Survey on Drug Abuse (NHSDA).

**Examination Components:** Survey. The survey excludes homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian, noninstitutionalized population of the U.S. aged 12 years old or older. NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases.	Age 12 and older	Black or African American; White, Hispanic or Latino (of any race)	Education; income; employment; health insurance	State <sup>27</sup>	First conducted in 1971 at various intervals and under different survey names; since 1990, the survey has been conducted annually	Public Use Files available here: <a href="http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/64">http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/64</a>	Available annually: <a href="http://archive.samhsa.gov/data/NSDUH.aspx">http://archive.samhsa.gov/data/NSDUH.aspx</a>

**Data Source:** National Mental Health Services Survey (<http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/34945>)

**Brief Description:** The National Mental Health Services Survey (N-MHSS) is designed to collect information from all specialty mental health facilities in the United States, both public and private. N-MHSS provides the mechanism for quantifying the dynamic character and composition of the U.S. mental health treatment delivery system. It is an annual survey designed to collect statistical information on the numbers and characteristics of all known mental health treatment facilities within the 50 states, the District of Columbia and the U.S. territories. In every other (even) year, beginning in 2014, the survey also collects statistical information on the numbers and demographic characteristics of persons served in these treatment facilities as of a specified survey reference date.

**Examination Components:** Survey; mental health facilities in the U.S., both public and private.

<sup>27</sup> Available since 1999. County- and metro-level data are available only through the Data Portal (restricted access). More information can be found at: <http://www.samhsa.gov/data/sites/default/files/NSDUH116/NSDUH116/NSDUHShortReport116AccessingData2012.htm>

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Data are collected on facility type, operations, and primary treatment focus; facility treatment characteristics; facility operating characteristics; facility management characteristics; and client demographics characteristics. N-MHSS collects data about facilities, not individual clients. Data on clients represent an aggregate of clients in treatment for each reporting facility.	–	Black or African American; White; Hispanic or Latino (of any race); Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native; Asian; Two or More Races.	–	State	June 2010 through January 2011 with a reference date of April 30, 2010	Public Use Files available at: <a href="http://www.wicpsr.umich.edu/icpsrweb/SAMHDA/studies/34945">http://www.wicpsr.umich.edu/icpsrweb/SAMHDA/studies/34945</a>	Available at: <a href="http://www.samhsa.gov/data/mental-health-facilities-data-nmhss/reports">http://www.samhsa.gov/data/mental-health-facilities-data-nmhss/reports</a>

**Data Source: National Survey of Substance Abuse Treatment Services (<http://www.dasis.samhsa.gov/dasis2/nssats.htm>)**

**Brief Description:** The National Survey of Substance Abuse Treatment Services (N-SSATS) is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS provides the mechanism for quantifying the dynamic character and composition of the U.S. substance abuse treatment delivery system.

**Examination Components:** Survey; public and private facilities in the U.S. that provide substance abuse treatment.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Data are collected on facility type, operations, and primary treatment focus; facility treatment characteristics; facility operating characteristics; facility management characteristics; client demographics, types of payment accepted, facility accreditation and licensure, and managed care agreements. N-SSATS collects data about facilities, not individual clients. Data on clients represent an aggregate of clients in treatment for each reporting facility.	N/A	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Two or More Races; Unknown; Not Collected	See information under target population	State	The N-SSATS evolved from national survey efforts begun in the 1970s by the National Institute on Drug Abuse. The sixth iteration, released in 1976, introduced the data elements and format that have formed the core of subsequent surveys. The N-SSATS was released as an annual survey in 2000. No survey was conducted in 2001.	Public Use Files	Data Spotlights, Topical Reports, Methodology Reports, Annual and Monthly available at: <a href="http://oas.samhsa.gov/dasis.htm#nssats3">http://oas.samhsa.gov/dasis.htm#nssats3</a>

**Data Source: State Synar Enforcement Reporting (<http://www.samhsa.gov/synar>)**

**Brief Description:** The Synar Regulation requires states (that is, all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and six Pacific jurisdictions) to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18. States must comply with the Synar Amendment in order to receive their full Substance Abuse Prevention and Treatment Block Grant (SABG) awards. Each state is also required to conduct annual, unannounced inspections that provide a valid probability sample of tobacco sales outlets accessible to minors, set targets to achieve a noncompliance rate of no more than 20%, and submit an annual report detailing activities to enforce the law .

**Examination Components:** Survey; respondents are in the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, Micronesia and the Marshall Islands.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
People < 18 years. The survey does not collect person-level data on individuals. Respondents are the retail tobacco outlets in the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions.	People < 18 years	–	Not collected	State	Annual report submitted by each state	No; public access to reports only	State websites provide public access to annual reports; annual Synar reports identify common characteristics among states that reach compliance goals and stress the importance of prevention in decreasing teen tobacco use): <a href="http://www.samhsa.gov/synar/annual-reports">http://www.samhsa.gov/synar/annual-reports</a>

**Data Source: Treatment Episodes Data Set (<http://www.dasis.samhsa.gov/dasis2/teds.htm>)**

**Brief Description: The** Treatment Episodes Data Set (TEDS) provides information on the demographic and substance abuse characteristics of admissions to treatment for age 12 and older for abuse of alcohol and/or drugs in facilities that report to individual state administrative data systems.

**Examination Components:** Survey; facilities that are licensed or certified by the state substance abuse agency to provide substance abuse treatment.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
TEDS collects data on demographic information (aged 12 and older), primary, secondary and tertiary substances and their route of administration, frequency of use, and age at first use, source of referral to treatment, number of prior treatment episodes, service type, including planned use of methadone; TEDS collects data about facilities, not individual clients; data on clients represent an aggregate of clients in treatment for each reporting facility	Age ≥ 12	–	–	State	Treatment episode data were first collected in 1973 through 1981 on an annual basis under a different name; data collection was discontinued in 1981; TEDS began in 1989 and is an annual data collection	Public Use Files Admissions: <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/56">http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/56</a> Discharge: <a href="http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/238">http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/238</a>	Data Spotlights, Topical Reports, Methodology Reports, Annual and Monthly



## Department of Health and Human Services Inter-agency Datasets

**Data Source:** Federal Interagency Forum on Aging Statistics, Older Americans Key Indicators of Well-Being ([http://www.agingstats.gov/agingstatsdotnet/Main\\_Site/About/About\\_Forum.aspx](http://www.agingstats.gov/agingstatsdotnet/Main_Site/About/About_Forum.aspx) )

**Brief Description:** The Federal Interagency Forum on Aging-Related Statistics (Forum) was initially established in 1986, with the goal of bringing together federal agencies that share a common interest in improving aging-related data. The Forum has played a key role by critically evaluating existing data resources and limitations, stimulating new database development, encouraging cooperation and data sharing among federal agencies, and preparing collaborative statistical reports. In addition to the original three core agencies (the National Institute on Aging, the National Center for Health Statistics and the Census Bureau), the organizing members of the Forum now include senior officials from the Administration on Aging, Agency for Healthcare Research and Quality, Bureau of Labor Statistics, Centers for Medicare & Medicaid Services, Department of Veterans Affairs, Employee Benefits Security Administration, Environmental Protection Agency, Office of Management and Budget, Office of the Assistant Secretary for Planning and Evaluation in HHS, Social Security Administration, and the Substance Abuse and Mental Health Services Administration. *Older Americans 2012: Key Indicators of Well-Being* is the sixth in a series of reports by the Forum, describing the overall condition of the United States population age 65 and over, available at [http://www.agingstats.gov/agingstatsdotnet/Main\\_Site/Data/2012\\_Documents/Docs/EntireChartbook.pdf](http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2012_Documents/Docs/EntireChartbook.pdf)

**Examination Components:** The reports use data from over a dozen national data sources to construct broad indicators of well-being for the older population and to monitor changes in these indicators over time.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population 65 and over	65-85+ disaggregated 65-74, 75-84, and 85 and over	All races/ethnicities	Sociodemographic characteristics	National	See available periodic reports	Yes. The following link leads to a list with descriptions of and links to the web sites of ongoing, federally sponsored surveys relevant to the aging. The surveys cover the range of concerns of the aging and are supported by a variety of federal agencies and departments. Data from these surveys are used to develop the reports for the Forum: <a href="http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/Resources.aspx">http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/Resources.aspx</a>	Available every four years (2000, 2004, 2008, 2010, 2012) at: <a href="http://www.agingstats.gov/agingstatsdotnet/main_site/default.aspx">http://www.agingstats.gov/agingstatsdotnet/main_site/default.aspx</a>

**Data Source:** Federal Interagency Forum on Child and Family Statistics, *Key National Indicators of Well-Being, 2010* (<http://www.childstats.gov/>)

**Brief Description:** *America's Children: Key National Indicators of Well-Being* is a report featuring statistics on children and families in the United States across a range of domains, including family and social environment, economic circumstances, health care, physical environment and safety, behavior, education and health. Each year since 1997, the Federal Interagency Forum on Child and Family Statistics has published a report on the well-being of children and families. Pending data availability, the Forum updates all 40 indicators annually on its website (<http://childstats.gov>) and alternates publishing the detailed report with a summary version that highlights selected indicators. The 2015 report includes a special feature on health care quality among children in the U.S. Available at: <http://www.childstats.gov/americaschildren/index.asp>.

**Examination Components:** Indicators of well-being; a working group of 22 federal agencies, the Forum fosters coordination, collaboration and integration of federal efforts to collect, analyze and report data on conditions and trends related to child and family well-being; the Forum also has partners in private research organizations.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Data are collected on children and families in the U.S.; the report does not collect person-level data on individuals	Infants/toddlers; children; youth (early teens to 18 years old)	White, non-Hispanic; Black, non-Hispanic; American Indian or Alaska Native, non-Hispanic; Asian, non-Hispanic; Native Hawaiian or Other Pacific Islander, non-Hispanic; Two or More Races, non-Hispanic	Family and social environment, economic circumstances, health care, physical environment and safety, behavior, education, health insurance	National	Each year since 1997, the Federal Interagency Forum on Child and Family Statistics has published a report on the well-being of children and families	The following link provides access to data source tools by agencies that contribute to this report: <a href="http://www.childstats.gov/data/sources/datatools.asp">http://www.childstats.gov/data/sources/datatools.asp</a>  Another relevant tool provides links to databases comparing the well-being of children in the U.S. with those in other countries: <a href="http://www.childstats.gov/data/sources/intnl links.asp">http://www.childstats.gov/data/sources/intnl links.asp</a>	Available upon request at: <a href="http://childstats.gov/pubs">http://childstats.gov/pubs</a>

**Data Source: Health Indicators Warehouse (<http://www.healthindicators.gov/>)**

**Brief Description:** The Health Indicators Warehouse (HIW) is a data hub of a collaborative effort among government and nongovernment partners to establish a network of suppliers and demanders of community health data, indicators and interventions. Its purpose is to help Americans access federal and other data on population health, determinants of health and the health care system and access, and to facilitate action to improve performance, outcome and value. The contact information for HIW is the National Center for Health Statistics (NCHS) at CDC.

**Examination Components:** HIW includes indicators from the Robert Wood Johnson Foundation/University of Wisconsin Population Health Institute County Health Rankings; Community Health Status Indicators; Healthy People 2020; Centers for Medicare & Medicaid (CMS) indicators (a set of community-level, Medicare utilization, sociodemographic, patient safety and quality indicators); and additional indicators as determined by the HHS Interagency Governance Group.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	Infants/toddlers ; children; youth (early teens to 18); young adults (18 years to 24); adults (25 years to 64); and older adults (65 years and older)	Yes, may differ by indicator	Differs by indicator; many population-based indicators include education and/or income	Varies by indicator; can be national, state, county or hospital referral region.  The warehouse is designed to provide summary health indicator data at a variety of geographic levels and for different populations. The indicators are constructed from individual-level data obtained from other governmental and private initiatives, and are presented at an aggregate level.	Varies; generally, from 2008 through most recent data available from the data source.	Available to the public.  A drop down list of data sources is available at <a href="http://www.healthindicators.gov/Resources/DataSources">http://www.healthindicators.gov/Resources/DataSources</a>	Federally sponsored health indicator reports are available at <a href="http://www.healthindicators.gov/Resources/Additional">http://www.healthindicators.gov/Resources/Additional</a>



## Datasets from Other Federal Agencies

### Department of Commerce, U.S. Census Bureau

**Data Source:** Current Population Survey (<http://www.census.gov/cps/about/>)

**Brief Description:** The Current Population Survey (CPS), sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is the primary source of labor force statistics for the population of the United States. The CPS is the source of numerous high-profile economic statistics, including the national unemployment rate, and provides data on a wide range of issues relating to employment and earnings. The CPS also collects extensive demographic data that complement and enhance our understanding of labor market conditions in the nation overall, among many different population groups in the states and in substate areas.

**Examination Components:** The CPS is administered by the Census Bureau using a probability selected sample of about 60,000 occupied households. The fieldwork is conducted during the calendar week that includes the 19<sup>th</sup> of the month. The questions refer to activities during the prior week; that is, the week that includes the 12<sup>th</sup> of the month. Households from all 50 states and the District of Columbia are in the survey for four consecutive months, out for eight, and then return for another four months before leaving the sample permanently. This design ensures a high degree of continuity from one month to the next (as well as over the year). The 4-8-4 sampling scheme has the added benefit of allowing the constant replenishment of the sample without excessive burden to respondents.

The CPS questionnaire is a completely computerized document that is administered by Census Bureau field representatives across the country through both personal and telephone interviews. Additional telephone interviewing is conducted from the Census Bureau's three centralized collection facilities in Hagerstown, MD; Jeffersonville, IN; and Tucson, AZ.

To be eligible to participate in the CPS, individuals must be 15 years of age or over and not in the Armed Forces. People in institutions, such as prisons, long-term care hospitals and nursing homes, are ineligible to be interviewed in the CPS. In general, the BLS publishes labor force data only for people aged 16 and over, since those under 16 are limited in their labor market activities by compulsory schooling and child labor laws. No upper age limit is used, and full-time students are treated the same as nonstudents. One person generally responds for all eligible members of the household. The person

who responds is called the “reference person” and usually is the person who either owns or rents the housing unit. If the reference person is not knowledgeable about the employment status of the others in the household, attempts are made to contact those individuals directly.

In addition to the regular labor force questions, the CPS often includes supplemental questions on subjects of interest to labor market analysts. These include annual work activity and income, veteran status, school enrollment, contingent employment, worker displacement and job tenure, among other topics. Because of the survey’s large sample size and broad population coverage, a wide range of sponsors use the CPS supplements to collect data on topics as diverse as expectation of family size, tobacco use, computer use and voting patterns.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All U.S. populations	Adults 25 years and older by education status; adults 18 years and older by veteran status; civilians 16 years and older	Black or African American; White; Hispanic or Latino (of any race); Asian or Pacific Islander	Earnings; educational attainment; employment; group quarters; Head Start; health insurance coverage; household; household, family or subfamily; size of household, nonfamily; householder; income measurement; income-to-poverty ratios, mean (average) income; median income; metropolitan-nonmetropolitan residence; per capita income; population coverage; poverty definition; rounding; size of household, family, or subfamily (see household, family, or subfamily, size of); school, dropout rate, annual high school; school enrollment; level of school; modal grade school; unemployment; units in structure; unmarried couple; unrelated individuals; vocational school enrollment; work experience	Census tract	(Surveys) CPS Supplements 2005–2012 (monthly, quarterly, annually)	Available publicly at: <a href="http://www.census.gov/cps/about/">http://www.census.gov/cps/about/</a>	Periodic reports available at: <a href="http://www.census.gov/hhes/www/income/publications/cps-reports.html">http://www.census.gov/hhes/www/income/publications/cps-reports.html</a>

**Data Source: Tobacco Use Supplement to the Current Population Survey (<http://appliedresearch.cancer.gov/studies/tus-cps/>)**

**Brief Description:** The Tobacco Use Supplement to the Current Population Survey (TUS-CPS) is a survey of tobacco use that has been administered as part of the U.S. Census Bureau's and the Bureau of Labor Statistic's Current Population Survey. From 1992-2000, the TUS-CPS was sponsored by the National Cancer Institute (NCI). The TUS-CPS is a key source of national and state level data on smoking and other tobacco use in the United States household population because it uses a large, nationally representative sample that contains information about 240,000 individuals within a given survey period.

Over the next 10 years, NCI and co-sponsor CDC) plan to conduct the TUS-CPS bi- or triannually, alternating between a Core questionnaire intended for monitoring purposes (similar to the questionnaire used throughout the 1990s) and more specific Special Topics questionnaires that target tobacco-related issues of particular interest to researchers. In 2001-2002, a Core TUS questionnaire has been fielded, using the same instrument as that administered in 1998-1999. In 2003, a Special Topics questionnaire oriented toward tobacco cessation will be fielded. Items include respondents' personal history of quit attempts over the preceding 12 months; level of nicotine addiction, and the nature of the quitting methods, products and treatment information that respondents have used in order to attempt to quit; quitting history and methods used for both cigarette smoking and other forms of tobacco (cigars, pipes, chewing tobacco and snuff); and information concerning the type of cigarette product used, and information related to harm reduction. (\*Description continued at: <http://aspe.hhs.gov/datacncl/DataDir/nih.htm> - tuscps)

**Examination Components:** The TUS-CPS is a key source of national, state and substate level data from U.S. households regarding smoking, use of tobacco products, and tobacco-related norms, attitudes and policies. It uses a large, nationally representative sample that contains information about 240,000 individuals within a given survey period.

Target Population	Age	Race & Ethnicity	Socio-Economic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Large, nationally representative sample	Adults 18 years-24; 25-44; 45-64; 65 years and older	White; Black; American Indian, Eskimo or Aleut; Asian or Pacific Islander; and Other	Collected via CPS: income; education; employment; marital status	Census tract	Intermittent data collection is active; data collected in 1992-1993, 1995-1996, 1998-1999, 2001-2002 and a few questions in 2000; special one-time Cessation Supplement will be fielded in 2003	<a href="http://appliedresearch.cancer.gov/tus-cps/info.html">http://appliedresearch.cancer.gov/tus-cps/info.html</a>	Tables from select years available: <a href="http://appliedresearch.cancer.gov/studies/tus-cps/publications.html">http://appliedresearch.cancer.gov/studies/tus-cps/publications.html</a>

## Appendix: Glossary of Acronyms

**ACL** – Administration for Community Living  
**AHRQ** – Agency for Healthcare Research and Quality  
**AIDD** – Administration for Intellectual and Developmental Disabilities  
**AoA** – Administration on Aging  
**CDC** – Centers for Disease Control and Prevention  
**CMS** – Centers for Medicare & Medicaid Services  
**EPA** – Environmental Protection Agency  
**FDA** – Food and Drug Administration  
**FIHET** – Federal Interagency Health Equity Team  
**HHS** – Department of Health and Human Services  
**HRSA** – Health Resources and Services Administration  
**IHS** – Indian Health Service  
**MCHB** – Maternal and Child Health Bureau  
**NCBDDD** – National Center on Birth Defects and Developmental Disabilities  
**NCCDPHP** – National Center for Chronic Disease Prevention and Health Promotion  
**NCEZID** – National Center for Emerging and Zoonotic Infectious Diseases  
**NCHHSTP** – National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention  
**NCHS** – National Center for Health Statistics  
**NCI** – National Cancer Institute  
**NCIRD** – National Center for Immunization and Respiratory Diseases  
**NHLBI** – National Heart, Lung, and Blood Institute  
**NIA** – National Institute on Aging  
**NIDA** – National Institute on Drug Abuse  
**NIDDK** – National Institute of Diabetes and Digestive and Kidney Diseases  
**NIH** – National Institutes of Health  
**NIMH** – National Institute of Mental Health  
**NPA** – National Partnership for Action to End Health Disparities  
**PHSPO** – Public Health Surveillance Program Office  
**SAMHSA** – Substance Abuse and Mental Health Services Administration

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Brief Description: The Federal Interagency Forum on Aging-Related Statistics (Forum) was initially established in 1986, with the goal of bringing together federal agencies that share a common interest in improving aging-related data. The Forum has played a key role by critically evaluating existing data resources and limitations, stimulating new database development, encouraging cooperation and data sharing among federal agencies, and preparing collaborative statistical reports. In addition to the original three core agencies (the National Institute on Aging, the National Center for Health Statistics and the Census Bureau), the organizing members of the Forum now include senior officials from the Administration on Aging, Agency for Healthcare Research and Quality, Bureau of Labor Statistics, Centers for Medicare & Medicaid Services, Department of Veterans Affairs, Employee Benefits Security Administration, Environmental Protection Agency, Office of Management and Budget, Office of the Assistant Secretary for Planning and Evaluation in HHS, Social Security Administration, and the Substance Abuse and Mental Health Services Administration. <i>Older Americans 2012: Key Indicators of Well-Being</i> is the sixth in a series of reports by the Forum, describing the overall condition of the United States population age 65 and over, available at <a href="http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2012_Documents/Docs/EntireChartbook.pdf">http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2012_Documents/Docs/EntireChartbook.pdf</a> )	166
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