COMPENDIUM OF FEDERAL DATASETS ADDRESSING HEALTH DISPARITIES

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PARTICIPATING DEPARTMENTS AND AGENCIES

U.S. Department of Health and Human Services

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)

Agency for Healthcare Research and Quality (AHRQ)

Centers for Disease Control and Prevention (CDC)

- National Center for Health Statistics

Centers for Medicare & Medicaid Services (CMS)

U.S. Food and Drug Administration (FDA)

Health Resources and Services Administration (HRSA)

Indian Health Service (IHS)

National Institutes of Health (NIH)

Substance Abuse and Mental Health Services Administration (SAMHSA)

U.S. Department of Agriculture (USDA)

U.S. Department of Commerce (DOC)

U.S. Department of Education (DOE)

U.S. Department of Housing and Urban Development (HUD)

U.S. Department of Justice (DOJ)

U.S. Department of Labor (DOL)

U.S. Department of Transportation (DOT)

U.S. Department of Veterans Affairs (VA)

U.S. Environmental Protection Agency (EPA)

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INTRODUCTION

The Compendium of Federal Datasets Addressing Health Disparities is a compilation of information on health equity data. This compendium is a useful resource for exploring data related to socioeconomic factors and social determinants of health. It includes datasets and data-related resources developed, maintained, or funded by federal agencies. The compendium is a work in progress that will continue to incorporate datasets and resources from agencies within the U.S. Department of Health and Human Services (HHS) and other federal partners.

The goal of the Compendium is to help address the critical need for more coordination and collaboration across sectors to reduce health inequities by improving access and dissemination of publicly available data and information. The audience for the Compendium is broad and includes researchers, program evaluators, grant writers, health officials, and other public health professionals who use data to produce evidence-based information to target interventions to improve health and wellness and address health inequities. The data compiled in this document provide a one-stop shop for understanding the landscape of federal datasets related to health equity, and ultimately, can help to shape and inform the development of effective programs, policies, and practices.

The inaugural Compendium was issued in November 2016. This version of the Compendium has been updated to include: 1) descriptions of over 250 databases from HHS and 9 other Departments/federal partners; 2) information on data sources relevant to opioid use/research; and 3) information on datasets with more controlled access (e.g. those available from biorepositories). The Compendium is an initiative of the Interdepartmental Health Equity Collaborative (IHEC), a platform hosted by the Office of Minority Health to encourage intersectoral collaboration across federal agencies to better address health disparities.

Compendium Dictionary

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:** Description of dataset components, which may include data collection procedures and data use
- **Target Population:** The population or group targeted for data collection (e.g., children, adults, individuals with disabilities)
- **Age:** Ages or age groups of the population included in the dataset
- **Race & Ethnicity:** How race and ethnicity data are collected in the dataset; for reference, the Office of Management and Budget (OMB) categories for race are White, Black or African American, Asian, Native Hawaiian or other Pacific Islanders, and American Indian or Alaska Native. Hispanic or Latino origin (i.e. ethnicity) is asked as a separate question.
- **Socioeconomic Variables:** List of socioeconomic variables (e.g., income, education, employment), if any, 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 data are available for public use
- **Periodic Reports:** Indicates whether reports are available and how frequently reports are generated from the data

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Data Source: Adoption and Foster Care Analysis and Reporting System (AFCARS) (https://www.ndacan.cornell.edu/datasets/dataset-details.cfm?ID=215)

Brief Description: AFCARS is a federally mandated data collection system intended to provide case specific information on all children covered by the protections of Title IV-B/E of the Social Security Act (Section 427).

Examination Components: AFCARS' reporting periods extend from October 1 to September 30 of the following year. One file contains adoption data and the other foster care data. Each adoption data file contains 37 elements that provide information on the adopted child's gender, race, birth date, ethnicity and prior relationship with the adoptive parents. The date the adoption was finalized, as well as dates parental rights were terminated, characteristics of birth and adoptive parents, and whether the child was placed from within the United States or from another country are also captured. The foster care data files contain 66 elements that provide information on child demographics, including gender, birth date, race, and ethnicity. Information about the number of previous stays in foster care, service goals, availability for adoption, dates of removal and discharge, funding sources, and the biological and foster parents is also included in the foster care files.

Table 1. Adoption and Foster Care Analysis and Reporting System

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children adopted and in foster care	Information available by age and gender	American Indian/Alaska Native; Asian; African American; Hawaiian Pacific Islander; White; Hispanic	Foster care payments, Medicaid, surgical site infections (SSI)	State, county	FY 1995-2016	Available	N/A

Data Source: Child Care and Development Fund (CCDF) Administrative Data Series (https://www.researchconnections.org/childcare/studies/36825)

Brief Description: The Personal Responsibility and Work Opportunity Act of 1996 requires states and territories to collect information on all family units receiving assistance through the CCDF and to submit monthly case-level data to the Child Care Bureau. This administrative dataset provides descriptive information about the families and children served through the federal CCDF.

Examination Components: The Summary Records file contains monthly state-level summary information, including the number of families served. The Family Records file contains family-level data, including single parent status of the head of household, monthly co-payment amount, date on which childcare assistance began, reasons for care (e.g., employment, training/education, protective services, etc.), income used to determine eligibility, and source of income. The Child Records file contains child-level data, including ethnicity, race, gender, and date of birth.

Table 2. Child Care and Development Fund

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Families receiving subsidies for childcare and their children	Information available by age and gender	Child data: American Indian/Alaska Native; African American; Two or more races; White; Hispanic	Family data: Household #, income, co-payments made to families	State	FY 2005-2014	Available	N/A

Data Source: The National Youth in Transition Database (NYTD) (https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/nytd, https://www.ndacan.acf.hhs.gov/datasets/datasets-list-nytd.cfm)

Brief Description: In 1999, Public Law 106-169 established the John H. Chafee Foster Care Independence Program to provide States with funding to carry out programs that assist youth in making the transition from foster care to self-sufficiency. The law required ACF to develop a data collection system to track services States provide and develop outcome measures to assess each States' performance. Data collection began October 2010.

Examination Components: States collect data on each you that receives independent living services, including demographic and outcome information on certain youth that the State will follow over time to collect addition outcome information.

Table 3. The National Youth in Transition Database

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Youth (17 years and older) transitioning out of the foster care system and receiving independent living services	Information available by age and gender	American Indian/Alaska Native; African American; Two or more races; White; Hispanic	Socioeconomic Variables are available	N/A	Cohort 1 – Data collected in FY 2011, 2012, 2013; Cohort 2 – FY 2016	TBD	N/A

Data Source: National Child Abuse and Neglect Data System (NCANDS) (https://www.ndacan.cornell.edu/datasets/datasets-list-ncands-child-file.cfm)

Brief Description: The NCANDS is a federally sponsored national data collection effort created for the purpose of tracking the volume and nature of child maltreatment reporting each year within the United States. The Child File is the case-level component of the NCANDS.

Examination Components: Submitted data consist of all investigations or assessments of alleged child maltreatment that received a disposition in the reporting year. Records are provided at the level of each child on a report, also known as the report-child pair. Data elements include the demographics of children and their perpetrators, types of maltreatment, investigation or assessment dispositions, risk factors, and services provided as a result of the investigation or assessment.

Table 4. National Child Abuse and Neglect Data System (NCANDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children and adolescents that have a filed report of abuse or maltreatment	Information available by age and gender.	American Indian/Alaska Native; Asian; African American; Hawaiian Pacific Islander; White; Hispanic	Financial Problem; Public Assistance; Inadequate Housing; Employment Services	State, county	1995-2015	Available	Child File data are collected annually through the voluntary participation of states.

U.S. 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 (https://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 non-work 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.

Table 5. Access to Integrated Employment: National Data Collection on Day and Employment Services for Citizens with Developmental Disabilities

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	National, State	Since mid-1980s	Data reports will be available on the ACL website (in development)	Online availability: https://www.statedata.info/about/data-sources

Data Source: Aging Integrated Databases (AGID) (https://agid.acl.gov/)

Brief Description: AGID is an online query system based on Administration on Aging (AoA)-related data files, population characteristics from the U.S. Census Bureau for comparison purposes, and links to Administration on Disabilities Programs Annual Performance Data and Programs Project of National Significance Data – Longitudinal Data Collection Project Information. 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). AGID additionally contains links to data on ACL disability programs.

Examination Components: 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. U.S. 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.

Table 6. Aging Integrated Databases (AGID)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	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 – ACS demographic data (2004-2012; population estimates data 2000-2012); Census 2010	Available online

Data Source: Data Collection for Supporting Families – Annual Monograph (https://acl.gov/programs/research-and-development/data-collection-projects)

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 AIDD within ACL.

Examination Components: FISP: Supporting Individuals and Families Information Systems Project (FISP). Establishes and refines a comprehensive program of annual data collection from states on family support, and conducts longitudinal data analysis, policy studies, and dissemination activities to better understand and promote effective supports for families and individuals with intellectual and/or developmental disabilities (IDD) who direct their own support. The data gathered will be used to help federal and state agencies understand the current status and emerging trends in supporting families and individuals with IDD living in homes of their own or with family members (including consumer direction). It will also be used to compare services and expenditures targeting the person with IDD versus those targeting the family members with whom they reside, and to compare services for children versus services for adults with IDD.

Table 7. Data Collection for Supporting Families – Annual Monograph

Target Population	Age	Race & Ethnicity	Socioeconomic 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 2011	Data reports will be available on the ACL website (in development)	Available online

Data Source: National Data Measurement Project: National Core Indicators – Annual Report (https://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 47 states contributing data.

Table 8. National Data Measurement Project: National Core Indicators – Annual Report

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	National, State	Since 1997	Data reports will be available on the ACL website (in development)	Available online

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

Brief Description: 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 intellectual/developmental disabilities (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).

Table 9. The National Residential Information System Project (RISP) – Biennial Monograph

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Data reports will be available on the ACL website (in development)	Available online

Data Source: Protection and Advocacy Systems (P&As) Program Performance Reports (http://www.acl.gov)

Brief Description: 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 can 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.

Table 10. Protection and Advocacy Systems (P&As) Program Performance Reports

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Data reports will be available on the ACL website (in development)	Available online

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.

Table 11. The State of the States in Developmental Disabilities – Biennial Monograph

Target Population	Age	Race & Ethnicity	Socioeconomic 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 1983	Data reports will be available on the ACL website (in development)	Available online

Data Source: University Centers for Excellence in Developmental Disabilities (UCEDD) Program Performance Reports (https://acl.gov/programs/aging-and-disability-networks/national-network-university)

Brief Description: 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.

Table 12. University Centers for Excellence in Developmental Disabilities (UCEDD) Program Performance Reports

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	National, State	Since 2003	Data reports will be available on the ACL website (in development)	Available online

U.S. 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: 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, healthcare, personal doctors and specialists.

Table 13. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey

Target Population	Age	Race & Ethnicity	Socioeconomic 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[1]	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

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[1] Other variables: Self-reported health status

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

Brief Description: 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).

Table 14. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey

Target Population	Age	Race & Ethnicity	Socioeconomic 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[2]	Region	2010-2013	Research files available upon request	Results are reported annually

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[2] Other variables: Health status

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

Brief Description: HCUP is a family of healthcare databases and related software tools and products developed through a federal-state-industry partnership and sponsored by AHRQ. 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 encounter-level healthcare 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 healthcare programs, and outcomes of treatments at the national, State, and local market levels.

Examination Components: AHRQ transforms administrative healthcare data acquired from HCUP Partners into research-ready, uniform databases with a common set of data elements. Currently, 48 Partners (47 States and the District of Columbia) provide HCUP with statewide inpatient data, 35 Partners provide ambulatory surgery and services data, and 35 Partners provide emergency department data. The inpatient data represent 97 percent of inpatient discharges from community hospitals. The National (Nationwide) Inpatient Sample (NIS) is the largest publicly available all-payer inpatient database in the United States, yielding national estimates of hospital inpatient stays. The NIS approximates 20 percent of the discharges from all U.S. community hospitals and contains data from more than seven million hospital stays each year. The Kids' Inpatient Database (KID) contains a sample of two to three million hospital pediatric discharges per year. The KID database is available every three years from 1997-2012. The Nationwide Emergency Department Sample (NEDS) includes approximately 30 million records each year for patients who were either treated in the ED and released or treated in the ED and admitted to the same hospital. The NEDS is released yearly. The Nationwide Readmissions Database (NRD) is released yearly. The State Inpatient Databases (SID) can be used to investigate questions that are unique to one State or to compare data from two or more States. The State Ambulatory Surgery and Services Databases (SASD) include encounter-level data for ambulatory surgery and other outpatient services from hospital-owned facilities. The State Emergency Department Databases (SEDD) contain discharge information on all ED visits that do not result in a hospital admission.

Table 15. Healthcare Cost and Utilization Project (HCUP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian non-institutionalized population	Adults and children ages 21 and younger	Hispanic, Non-Hispanic White, Non-Hispanic API, Non-Hispanic Black (from National Healthcare Quality and Disparities Report HCUP Disparities File)	Health insurance status, location of patient residence, median income of patient's ZIP, region, teaching status of hospital	Large Fringe Metro, Medium Metro, Micropolitan, Non-core, Small Metro	Since 1998	Data available for purchase/data user agreement: https://www.hcup-us.ahrq.gov/databases.jsp	HCUP disparities data are reported annually in the National Healthcare Quality and Disparities Report The HCUP Disparities file is created specifically for the National Report. Data tables are accessible at https://nhqrnet.ahrq.gov/inhqrdr/data/query

Data Source: Medical Expenditure Panel Survey (MEPS) (AHRQ) (https://meps.ahrq.gov/mepsweb/)

Brief Description: The Medical Expenditure Panel Survey, 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 United States. 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.

Examination Components: MEPS currently has two major components: The Household Component and the Insurance Component. The Household Component provides data from individual households and their members, which is supplemented by data from their medical providers. The Insurance Component is a separate survey of employers that provides data on employer-based health insurance. Other components include a Medical Provider Component (MPC).

Table 16. Medical Expenditure Panel Survey (MEPS) (AHRQ)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian, non-institutionalized population	Information available by age and gender	AI/AN, Asian, Black, multiple race, NHOPI, White, Hispanic, non-Hispanic White, Non-Hispanic Black	Age, sex, race, ethnicity, activity limitation, employment status, income, perceived health status, preferred language, insurance, U.S. born, education, location of residence	Large Fringe Metro, Medium Metro, Micropolitan, Noncore, Small Metro	1998-present	Publicly available, data files delayed by one year Restricted data files: Researchers with approved projects can access Household Component data files not available for public use at the AHRQ Data Center, located in Rockville, Maryland, or at one of the Census Bureau's Research Data Centers. Except for directly identifiable data, all data elements collected in the Household Component that have not been publicly released are available at the Data Center	MEPS publishes Stat Briefs, chartbooks and other publication. MEPS disparities data also reported annually in the National Healthcare Quality and Disparities Report The National Healthcare Quality and Disparities Report data tables are accessible at https://nhqrnet.ahrq.gov/inhqrdr/data/query

Data Source: National Healthcare Quality Report and National Healthcare Disparities Report (https://nhqrnet.ahrq.gov/inhqrdr/)

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 healthcare.

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

Table 17. National Healthcare Quality Report and National Healthcare Disparities Report

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All populations, (depending on dataset)	All ages	All races/ethnicities-depending on the data set	Socioeconomic demographics	National, State	Since 2003	Available at https://nhqrnet.ahrq.gov/inhqrdr/data/query https://nhqrnet.ahrq.gov/inhqrdr/state/select	NHQR and NHDR chart books are available yearly

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Data Source: Adult Blood Lead Epidemiology & Surveillance (ABLES) Program (https://www.cdc.gov/niosh/topics/ables/data.html)

Brief Description: The ABLES Program is maintained by the National Institute for Occupational Safety and Health (NIOSH). ABLES is a state-based surveillance program of laboratory-reported adult blood lead levels (BLLs). The main objective of the ABLES program is to cooperate with state programs to reduce the rate of adults with elevated BLLs. State ABLES programs 1) collect data on adult BLLs from laboratories and physicians through mandatory reporting; 2) assign unique identifiers to each adult to account for multiple BLL records per person, protect individual privacy, and permit longitudinal analyses; 3) follow-up on adults with BLLs ≥10 or ≥25 µg/dL with laboratories, healthcare providers, employers, or workers to ensure completeness of information (e.g., the industry in which the adult is employed and whether the exposure source is occupational, non-occupational, or both); 4) provide guidance and information to workers and employers to prevent lead exposures; and 5) submit data annually to NIOSH. Most ABLES states submit data on all BLLs (both occupational and non-occupational) to NIOSH, including records from adults whose BLLs fall below the state mandatory reporting requirement. NIOSH consolidates data from reporting state ABLES programs, conducts data quality control, analyzes the data, and disseminates the findings among stakeholders.

Examination Components: Administrative and demographic data, industry for work-related cases, BLLs, and exposure source.

Table 18. Adult Blood Lead Epidemiology & Surveillance (ABLES) Program

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Population: adults who are exposed to lead in participating states	16 years and older	Hispanic (separate question), White, Black or African American, Asian, American Indian & Alaskan Native, Hawaiian/Pacific Islanders, Other. **This information is only available for about 20 percent of the records	Industry and occupation for work-related cases	State/County	1987 – present	Data and statistics available for public use at https://www.cdc.gov/niosh/topics/ables/data.html or https://wwwn.cdc.gov/niosh-whc/chart/ables-ab	Annual reports available at https://www.cdc.gov/niosh/topics/ables/data.html and publications in Morbidity and Mortality Weekly Report (MMWR) and peer-reviewed journals available at https://www.cdc.gov/niosh/topics/ables/publication.html

Data Source: Alaska Invasive Bacterial Disease Surveillance (https://stacks.cdc.gov/cbrowse?pid=cdc%3A44839&parentId=cdc%3A44839)

Brief Description: The Arctic Investigations Program (AIP) conducts disease surveillance in Alaska to monitor how many people get sick from certain infections. Disease surveillance focuses on diseases that are of high concern to Alaska Native people. AIP works with over 20 hospitals and clinics across Alaska to monitor these diseases. Specimens of certain disease-causing organisms are sent to the AIP laboratory for confirmation, drug-susceptibility and special testing. Measuring how much disease occurs in Alaska helps AIP and other health officials to know if a prevention program is working, recognize disease outbreaks, and decide how to improve prevention and control activities. AIP monitors these types of invasive disease-causing bacteria: Haemophilus influenzae, Streptococcus pneumoniae, Neisseria meningitidis, Groups A and B Streptococcus and Helicobacter pylori.

Alaska also participates in the International Circumpolar Surveillance (ICS), a surveillance network of circumpolar countries. By sharing surveillance information from Alaska with other circumpolar regions, AIP receives information about new and possible infections in the Arctic. These reports are available in CDC stacks: https://stacks.cdc.gov/cbrowse?pid=cdc%3A44839&parentId=cdc%3A44839.

Examination Components: In the statewide surveillance system for invasive diseases caused by Streptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis, and groups A and B streptococci, laboratories throughout the state are requested to send to AIP any isolates of these organisms recovered from a blood culture, CSF or other normally sterile site in an Alaska resident. Isolate identification is confirmed and, when appropriate, serotyped and tested for antimicrobial susceptibility.

Table 19. Alaska Invasive Bacterial Disease Surveillance

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
As CDC's infectious disease field station in Alaska, AIP focuses on the people of northern circumpolar regions with the aim of reducing health disparities related to infectious diseases. The target population are residents of the State of Alaska	<2, 2-4, 5-18, 19-54, 55-64, 65+ or continuously in years; M/F sex	Data are reported by racial group: Alaska Native and non-Native Alaskans	Not collected as part of routine public health surveillance	Region (Anchorage, Arctic Slope, Bristol Bay, Interior, Kotzebue, Norton Sound, Southeast, YK Delta)	1980-ongoing (depending on the disease)	NCEZID/DPEI/Arctic Investigations Program in Anchorage provides certain organizations (e.g., Alaska Native Tribal Health Consortium, Alaska Department of Health and Social Services) access to data that cannot be released publicly (data that contains individually identifiable or potentially identifiable information). AIP's data sharing is through a special data use agreement that governs their use and further release. Before making their data available, NCEZID/DPEI/AIP evaluates requests for permission to use confidential or private information to ensure these data are appropriate for the use sought, will be used consistently with any applicable legal restrictions on the data, and will be used for an appropriate purpose. Eight Artic Investigations Program datasets are shared with tribal health partners under protocols	Various reports from the Alaska Invasive Bacterial Disease Surveillance and 1-page summaries of the organism-specific surveillance easily accessible. Thirty Arctic Investigations Program surveillance data reports have been placed in CDC stacks (2000 – 2016). https://stacks.cdc.gov/cbrowse?pid=cdc%3A44839&parentId=cdc%3A44839

Data Source: Alcohol-Related Disease Impact System (ARDI) (http://nccd.cdc.gov/DPH_ARDI/)

Brief Description: ARDI is an online application that provides national and state estimates of alcohol-related health impacts, including deaths and years of potential life lost (YPLL). Both alcohol-attributable deaths (AAD) and YPLL are calculated using current population estimates of the total proportion of deaths for various causes that are attributable to alcohol use. These proportions, called alcohol-attributable fractions (AAF), were either measured directly or calculated indirectly based on current scientific literature.

Examination Components: The national and state estimates are calculated for 54 acute and chronic causes using AAF and are reported by age and sex for 2006-2010.

Table 20. Alcohol-Related Disease Impact System (ARDI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Alcohol-attributable mortality	ARDI is only able to stratify AAD and YPLL by sex and age. Age groups: 0-19, 20-34, 35-49, 50-64, and 65+	No, the current version of ARDI is only able to stratify AAD and YPLL by sex and age	N/A	State	2006-2010	The Custom Data User feature allows you to conduct your own analyses of alcohol-attributable harms in the ARDI application using local data (https://nccd.cdc.gov/DPH_ARDI/Default/Default.aspx). ARDI data are also included in the CDC Chronic Disease and Health Promotion Open Data Site. This site allows you to create filtered datasets and customize visualizations, as well as quickly access a wide range of chronic disease data, risk factor indicators, and policy measures. Learn more at the Chronic Disease and Health Promotion Open Data site. (https://chronicdata.cdc.gov/browse?category=Alcohol-Related+Disease+Impact)	N/A

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

Brief Description: EHDI programs are in states and territories, and work to identify deaf and hard of hearing infants early and enroll these infants in intervention programs aimed at helping them develop communication skills. CDC supports and collaborates with states in the development and implementation of EHDI data and surveillance systems to ensure that all infants are screened for hearing loss and receive appropriate follow-up services. States voluntarily report data related to screening and follow-up services through an 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 reflects data that states and territories have documented without any estimation. As a result, data reported by CDC EHDI may differ from other national sources.

Table 21. Annual Early Hearing Detection and Intervention (EHDI) Program, Hearing and Screening Follow-Up Survey

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Infants	Infants	Hispanic or Latino / White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander (limited availability of this data)	N/A	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	Data summaries available on CDC website	Available online

Data Source: Antibiotic Resistance Patient Safety Atlas (AR Atlas) (http://www.cdc.gov/hai/surveillance/ar-patient-safety-atlas.html)

Brief Description: The Patient Safety Atlas reports percent resistance among healthcare-associated infections (HAIs). Pooled mean proportion of isolates testing resistant to specific antibiotics among all isolates tested, reported to CDC's National Healthcare Safety Network (NHSN) as central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and SSIs. In addition, information is presented about the occurrence of specific HAIs, as detailed below, using the Standardized Infection Ratio (SIR) metric, and aggregated by state and type of healthcare facility. The use of SIR allows monitoring of each HAI type over time nationally and by state.

Examination Components: The data is from 4,403 facilities that reported at least one HAI to NHSN, including: 3,676 acute care hospitals, 506 long-term acute care hospitals and 221 inpatient rehabilitation facilities. Due to insufficient data, long-term care and skilled nursing facilities are not included at this time. The data shown in the AR Atlas were gathered after one of three key types of infections occurred in the hospital: CLABSI, CAUTI and Surgical site infections (SSI). At the national level, SSI data reflect all types of SSIs (superficial, deep, and organ/space) that occurred following any of the 39 NHSN inpatient procedures and were performed between 2011-2014. The AR Atlas includes resistance data for 31 bug-drug profiles (or phenotypes, pathogen-antibiotic combinations that are used to describe the bacteria's resistance to a specific drug(s)). These phenotypes include Methicillin-resistant Staphylococcus aureus (MRSA), Carbapenem-resistant Enterobacteriaceae (CRE) and Multidrug-resistant Pseudomonas aeruginosa. See methodology: https://gis.cdc.gov/grasp/PSA/downloads/AR-Data-Methodology.pdf. Data on HAIs are shown using the SIR metric and aggregated by state and by healthcare facility type. These data are reported by healthcare facilities to NHSN. See methodology: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf In addition, data on outpatient oral antibiotic prescriptions dispensed by U.S. community pharmacies and mail order pharmacies are acquired by the Xponent database from IQVIA (Danbury, CT) and aggregated by state and antibiotic class. See methodology: https://gis.cdc.gov/grasp/PSA/Downloads/OAU-Data-Methods.pdf No R&E or SE data was used in this project.

Table 22. Antibiotic Resistance Patient Safety Atlas (AR Atlas)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients at facilities reporting HAIs to NHSN	Age Category (<1, 1-18, 19-64, 65+, All ages), Gender (M, F, Unknown/other)	N/A	N/A	State, region	The AR Atlas includes 2011-2014 AR and inpatient antibiotic stewardship data reported to CDC's National Healthcare Safety Network. NHSN has been collected from 2004-2017. It also contains HAI data for 2016-2017, collected by NSHN, and outpatient oral antibiotic prescription data from the Xponent database from IQVIA (Danbury, CT) from 2011-2016 (updated May 2019)	The Atlas can be accessed at: https://gis.cdc.gov/grasp/PSA/. NHSN Data can be accessed at: https://www.cdc.gov/nhsn/datastat/index.html	The AR Threat Report, also based on the National Healthcare Safety Network can be accessed at https://www.cdc.gov/drugresistance/threat-report-2013/index.html. Note that the AR Atlas data help inform, but do not replace, national estimates of cases of infection in the U.S. reported by CDC in the Antibiotic Resistance Threats in the United States, 2013 (AR Threat Report). The AR Threat Report published in 2013 used NHSN data from 2010-2012 in combination with other national surveillance and prevalence survey data to extrapolate estimates

Data Source: AtlasPlus (https://www.cdc.gov/nchhstp/atlas/index.htm)

Brief Description: AtlasPlus is an interactive tool that gives users the ability to create customized tables, maps, and charts using more than 15 years of CDC's surveillance data on HIV, viral hepatitis, sexually transmitted disease (STD), and tuberculosis (TB). 2017 surveillance data for HIV and TB and 2016 surveillance data for viral hepatitis and STDs are available (https://www.cdc.gov/nchhstp/atlas/whats-new.html).

Examination Components: AtlasPlus also provides access to indicators on social determinants of health (SDOH) allowing users to view social and economic data in conjunction with surveillance data for each disease. HIV incidence and prevalence data (e.g., estimated incidence, estimated diagnosed HIV among those living with HIV infection, and estimated persons living with HIV infection nationally and by state). Additional state and county-level HIV surveillance data (e.g., demographic /risk stratifications [age group, race/ethnicity, sex, and transmission categories] by state [up to four stratifications] and county [up to 3-way stratifications]).

Table 23. AtlasPlus

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. case reports reported to CDC, U.S., DC and territories	All ages	All races and ethnicities	N/A	County	2000-present	Available at https://www.cdc.gov/nchhstp/atlas/index.htm	All information available online. No reports.

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

Brief Description: The 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 prevalence and 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).

Table 24. Autism and Developmental Disabilities Monitoring Network (ADDM)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children with autism	Children aged 4 years and 8 years	Non-Hispanic White; Non-Hispanic Black (or African American); Hispanic (or Latino); Non-Hispanic Asian/Pacific Islander; Non-Hispanic American Indian or Alaska Native; Non-Hispanic Other/Multiracial	ADDM Network data can be linked to census-based data on socioeconomic status	Currently consists of 11 participating sites: Arkansas Arizona Colorado Georgia Maryland Minnesota Missouri New Jersey North Carolina Tennessee Wisconsin	2000 – present, biennial	Restricted access upon request. To request please send proposals to mailto:NCBDDDData@cdc.gov	Every two years

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) (https://www.cdc.gov/brfss/data_documentation/index.htm)

Brief Description: BRFSS is the nation's premier system of telephone surveys that collect state data about health risk behaviors, chronic health conditions, and use of preventive services among U.S. residents. For more than 30 years, the Centers for Disease Control and Prevention (CDC), all 50 states, the District of Columbia (DC), and participating U.S. territories have used the BRFSS to collect uniform, state-specific information about a wide range of behaviors that affect the health of U.S. adults.

Examination Components: BRFSS collects state data about U.S. residents regarding their health-related risk behaviors and events, chronic health conditions, and use of preventive services. BRFSS also collects data on important emerging health issues, such as vaccine shortage and influenza-like illness. For example, since September 2009, federal, state, and local health agencies have used BRFSS to monitor the prevalence rates of influenza-like illness to help with pandemic planning. Interviewers administer the annual BRFSS surveys continuously through the year.

Table 25. Behavioral Risk Factor Surveillance System (BRFSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. civilian non-institutionalized age 18 years and over, residing in households	Aged 18 or older; Male, Female	Hispanic, Latino(a), or Spanish origin; White; Black or African American; American Indian or Alaska Native; Asian; Pacific Islander; Other	Education; income; health insurance; access to healthcare; type of insurance	All 50 states, the District of Columbia (DC), and participating U.S. territories, and metropolitan/micropolitan areas	1984-present (annually)	Available at https://www.cdc.gov/brfss/data_documentation/index.htm	Available at https://www.cdc.gov/brfss/publications/index.htm

Data Source: Breastfeeding Report Card (https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf and https://www.cdc.gov/breastfeeding/data/reportcard.htm)

Brief Description: The 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 childcare settings.

Table 26. Breastfeeding Report Card

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	N/A	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 https://www.cdc.gov/breastfeeding/data/reportcard.htm

Data Source: Chronic Disease State Policy Tracking System (https://chronicdata.cdc.gov/Nutrition-Physical-Activity-and-Obesity/CDC-Nutrition-Physical-Activity-and-Obesity-Legisl/nxst-x9p4)

Brief Description: Effective October 2, 2017, the Chronic Disease State Policy Tracking System will no longer be updated but will remain available for reference. Recognizing the unique role that states play in promoting health and preventing disease, CDC monitored 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).

Table 27. Chronic Disease State Policy Tracking System

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	N/A	N/A	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 This dataset is no longer active, but is still accessible at: https://chronicdata.cdc.gov/Nutrition-Physical-Activity-and-Obesity/CDC-Nutrition-Physical-Activity-and-Obesity-Legisl/nxst-x9p4	The data, including policies, are made available solely for the purpose of public health information, research, and surveillance

Data Source: Clinical Assessment of Subjects with Chronic Fatigue Syndrome (CFS) and Other Fatiguing Illnesses in Wichita (Wichita Clinical Study Data) (https://www.cdc.gov/me-cfs/programs/wichita-data-access.html)

Brief Description: This is a two-day in-hospital study conducted from December 2002 to July 2003, and participants were previously identified in the Wichita (Kansas, USA) 4-year longitudinal surveillance study. All study subjects were classified as 1) Meeting the 1994 CFS international case definition (CFS); 2) Meeting the 1994 CFS international case definition except that a major depressive disorder with melancholic features was identified (CFS-MDDm); 3) Chronically fatigued but not meeting the 1994 CFS international case definition because of insufficient number of symptoms or fatigue severity (ISF); 4) Chronically fatigued but with ISF and a major depressive disorder with melancholic features (ISF-MDDm); and 5) Non-fatigued controls individually matched to CFS subjects on age, race/ethnicity, sex and body mass index (BMI) (NF).

Examination Components: The data sets were collected during a two-day in-hospital clinical assessment study conducted from December 2002 to July 2003 in Wichita, KS, USA (referred to as Wichita Clinical Study). The study enrolled 227 people and classified them into study groups. Assessment included clinical evaluation of each subject's medical and psychiatric status, sleep characteristics and cognitive functioning. Laboratory testing evaluated neuroendocrine status, autonomic nervous system function, systemic cytokine profiles, peripheral blood gene expression patterns and polymorphisms in genes involved in neurotransmission and immune regulation.

Table 28. Clinical Assessment of Subjects with Chronic Fatigue Syndrome (CFS) and Other Fatiguing Illnesses in Wichita (Wichita Clinical Study Data)

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
A cohort of approximately 5,000 people, including persons with CFS, other fatiguing illnesses and non-fatigued controls, from Sedgwick County, Kansas that had previously been identified through a longitudinal surveillance study	Age, sex (male/female)	Race (White, Black, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple Races) and ethnicity (Hispanic, non-Hispanic)	N/A	County (Sedgwick County)	December 2002 to July 2003	The data source is considered restricted data. CDC's Chronic Viral Diseases Branch is making the data accessible to researchers through CDC's NCHS (National Center for Health Statistics) Research Data Center (RDC). All researchers and users interested in the data shall be subject to all RDC procedures and protocols, so this data will not be downloadable and may be accessible onsite only. The details of this data access are available on https://www.cdc.gov/me-cfs/programs/wichita-data-access.html	See the Wichita Clinical Study Overview for publications: https://www.cdc.gov/me-cfs/pdfs/wichita-data-access/wichita-clinical-study-overview.pdf

Data Source: Community Counts (CC) (https://www.cdc.gov/ncbddd/hemophilia/communitycounts/about.html)

Brief Description: CC collects routine clinical information from the U.S. network of Hemophilia Treatment Centers (HTCs) in order to describe the epidemiologic characteristics of people with bleeding disorders and to monitor health indicators of importance to the bleeding disorders population. CC consists of three components, the HTC Population Profile, the Registry for Bleeding Disorders Surveillance, and Mortality Reporting.

Examination Components: CC 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; hospitalizations; absences from school or work; joint disease, overall activity level and pain; inhibitor status; other medical conditions and procedures; and blood samples to check for viruses and inhibitors.

Table 29. Community Counts (CC)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Persons with bleeding disorders, primarily those due to congenital factor deficiencies, such as hemophilia, VWD, and other rare clotting factor deficiencies	All ages	Race: American Indian/Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Unknown; Ethnicity: Hispanic, Latino/a, or Spanish origin; Not Hispanic, Latino/a, or Spanish origin; Unknown	Education; health insurance; employment status	National, regional	2012 – present	Only in aggregate	Semi-annual national reports from the HTC Population Profile are available to the public; national reports from the Registry are under development

Data Source: Data Set Directory of Social Determinants of Health at the Local Level (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. A brief overview of the literature is provided for each dimension.

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 non-traditional sources. Datasets for the following 12 dimensions of social determinants of health are included: economy, employment, education, political, environmental, housing, medical, governmental, public health, psychosocial, behavioral, transportation.

Table 30. Data Set Directory of Social Determinants of Health at the Local Level

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	A variety of ages, usually women and men combined	Varies by dimension	Economy, employment, education, political, environmental, housing, psychosocial	Geographic units vary by dimension, but can include country, census tract, zip code and/or state	Most of the datasets are ongoing, routinely collected	Publicly available	N/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 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.

Table 31. Disability and Health Data System

Target Population	Age	Race & Ethnicity	Socioeconomic 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/Multiracial	Income; education; employment status; Veteran status; health risk and behaviors; barriers and costs of healthcare	State	2004-2012	Available publicly at: http://dhds.cdc.gov/ Most data displayed in DHDS come from BRFSS. Additional data sources used to calculate disability-associated healthcare expenditures are: the National Health Interview Survey (NHIS), MEPS, and the National Health Expenditure Accounts (NHEA)	Maps and Data Tables are available and allow generation of reports, at https://dhds.cdc.gov/dataviews/

Data Source: Electronic Report of Verified Case of Tuberculosis (https://www.cdc.gov/tb/statistics/default.htm)

Brief Description: The Report of Verified Case of Tuberculosis is the national Tuberculosis (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.

Table 32. Electronic Report of Verified Case of Tuberculosis

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with tuberculosis	All ages	All races and ethnicities	N/A	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 seven 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 https://www.cdc.gov/tb/statistics/tbcases.htm. Also, customized data tables are available through https://wonder.cdc.gov/tb.html and https://www.cdc.gov/nchhstp/atlas/	Reported tuberculosis in the United States, 2014, available at http://www.cdc.gov/tb/statistics/reports/2014/default.htm

Data Source: Emerging Infections Program Network (EIP) (https://www.cdc.gov/ncezid/dpei/eip/index.html)

Brief Description: The 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 healthcare 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. Active population-based surveillance activities conducted throughout the EIP Network include: laboratory surveillance for invasive bacterial diseases, such as groups A and B streptococcus with the Active Bacterial Core surveillance (ABCs) program; 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 through FoodNet; surveillance for influenza-related hospitalizations and influenza vaccine effectiveness evaluations through FluSurv-NET; establishing the pre-vaccine burden of respiratory syncytial virus (RSV) among all age groups is an essential component for evaluating the evidence for vaccine use in all age groups through EIP RSV surveillance; surveillance for Clostridium difficile infection and other healthcare-associated infections caused by pathogens, such as MRSA, Candida, and multi-drug resistant gram-negative bacteria through Healthcare-Associated Infections – Community Interface (HAIC) projects; monitoring the impact of Human Papillomavirus (HPV) vaccination on population health through the HPV-IMPACT project; and applied research of tickborne diseases through TickNET.

Examination Components: The EIP population is roughly representative of the U.S. population based on demographic characteristics, such as age, gender, race, and urban residence, as well as health indicators, such as population density and percent at or below the poverty level. The network comprises a catchment area of approximately 49 million people, though this varies by project. Surveillance efforts of the core EIP activities generate reliable estimates of the incidence of certain infections and provide the foundation for a variety of epidemiologic studies to explore risk factors, spectrum of disease, and prevention strategies.

Table 33. Emerging Infections Program Network (EIP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Residents of surveillance areas in California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, Oregon, Tennessee	Includes all ages; information on sex is collected	Includes race and ethnicity data where possible (Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Multiple)	Socioeconomic data can be described through other publicly available data sources (e.g., linked to American Community Survey)	Data are routinely described by surveillance catchment area or state (CA, CO, CT, GA, MD, MN, NM, NY, OR, TN)	1995-present, varying by activity	Contact individual programs to inquire about accessing data. https://www.cdc.gov/ncezid/dpei/eip/index.html	Publications are available at: https://www.cdc.gov/ncezid/dpei/eip/eip-publications.html Project-specific annual reports: ABCs https://www.cdc.gov/abcs/index.html; FoodNet: https://www.cdc.gov/foodnet/reports/index.html; HAIC: https://www.cdc.gov/hai/eip/index.html; FluSurv-NET: https://www.cdc.gov/flu/weekly/ RSV: https://www.cdc.gov/rsv/ HPV-IMPACT: https://www.cdc.gov/ncird/surveillance/hpvimpact/index.html; TickNET: https://www.cdc.gov/ticknet/research/

Data Source: Foodborne Diseases Active Surveillance Network (FoodNet) (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.

Table 34. Foodborne Diseases Active Surveillance Network (FoodNet)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Surveillance areas represent 42 million persons; 14 percent 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: http://www.cdc.gov/foodnet/ or http://www.cdc.gov/ncezid/dfwed/edeb/reports.html	Morbidity and Mortality Weekly Report, 1996-2012; MMWR (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: HIV Surveillance System (https://www.cdc.gov/nchhstp/atlas/)

Brief Description: The 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.

Table 35. HIV Surveillance System

Target Population	Age	Race & Ethnicity	Socioeconomic 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	All ages	All races and ethnicities	Data include demographic characteristics, living status, mode of exposure to HIV and case definition category. Also includes birthplace, acculturation questions regarding language usually spoken at home, selected diseases and conditions, including HIV and STDs, drug use, perceived community tolerance and perceived stigma	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 to 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 http://www.cdc.gov/nchhstp/atlas/	HIV surveillance Reports available at http://www.cdc.gov/hiv/library/reports/surveillance/

Data Source: Interactive Atlas of Heart Disease and Stroke Prevention (https://nccd.cdc.gov/dhdspatlas/)

Brief Description: The Interactive Atlas of Heart Disease and Stroke is an online mapping tool that allows users to create and customize county-level maps of heart disease and stroke by race and ethnicity, gender, age group, and more.

Examination Components: Cardiovascular Diseases & Risk Factors; Mortality, Hospitalizations, Hospital Discharge Status.

Table 36. Interactive Atlas of Heart Disease and Stroke Prevention

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults age 35 years and older	Ages 35+; 45-64; 65+; <75 Male, Female	White, Black, Hispanic, American Indian/Alaska Native, Asian/Native Hawaiian/Other Pacific Islander	Social environment: Education; Female-headed households; Food stamp/Supplemental Nutrition Assistance Program (SNAP) recipients; Median home value; Median household income; Income inequality; Poverty; Unemployment. Physical Environment: Air Quality; Park Access; Severe Housing Problems	Counties; census tracts	2005-2007 forward	Publicly available	N/A

Data Source: Medical Monitoring Project (MMP) (https://www.cdc.gov/hiv/statistics/systems/mmp/index.html)

Brief Description: MMP is a surveillance project designed to learn more about the experiences and needs of people living with a diagnosis of HIV infection. It is conducted by state and local health departments with funding and support from CDC/NCHHSTP.

Examination Components: From 2005-2014 the sample included person receiving care for HIV. Since 2015 MMP samples from all persons living with a diagnosis of HIV infection. Interviews and medical record abstraction are conducted to ascertain participant demographic characteristics, income, health insurance coverage, method of payment for HIV-related drugs, met and unmet HIV-related care needs and HIV care outcomes.

Table 37. Medical Monitoring Project (MMP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults living with a diagnosis of HIV infection in the U.S. A sample of 16 states, 6 separately funded cities within those states, and one territory were selected from among the 50 states and Puerto Rico	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; stigma; met and unmet HIV-related care needs; and HIV care outcomes	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 one 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, previously, MMWR surveillance summaries

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

Brief Description: The 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.

Table 38. Morbidity and Mortality Weekly Report (MMWR)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
N/A	N/A	N/A	N/A	N/A	N/A	Weekly reports available at http://www.cdc.gov/mmwr/index2015.html	Weekly reports; recommendations and reports; surveillance summaries

Data Source: National Cardiovascular Disease Surveillance System Data Trends & Maps (https://www.cdc.gov/dhdsp/maps/dtm/index.html)

Brief Description: The CDC Division for Heart Disease and Stroke Prevention's Data Trends & Maps online tool allows you to search for and view health indicators related to heart disease and stroke prevention. You can search based on a specific location, data source, or health indicator.

Examination Components: Cardiovascular Diseases & Risk Factors; Mortality, Hospitalizations, and Prevalence.

Table 39. National Cardiovascular Disease Surveillance System Data Trends & Maps

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults age 18 years and older	Age: 18-24; 25-44; 45-64; 65+; 75+; 35+ / Gender: Men; women	Non-Hispanic White; Non-Hispanic Black; Non-Hispanic Asian; Hispanic; Mexican American	N/A	State	1999 forward	Publicly available	No reports

Data Source: National Environmental Public Health Tracking Network (Tracking Network) (https://ephtracking.cdc.gov/)

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, you can view maps, tables, and charts with data about:

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

Examination Components: 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 air and water pollutants, in the environment.
- Exposure data: Data about the amount of an environmental chemical in a population.
- Other data: Data that can help improve our understanding about relationships between exposures and health effects, including demographics, socioeconomic factors, and health status (e.g., disabilities, health insurance status).

Table 40. National Environmental Public Health Tracking Network (Tracking Network)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All ages, but specific age group categories vary depending on the data source	Race and ethnicity data vary depending on the data source	Median household income; number and percent of people over the age of 16 who are unemployed; number and percent of people aged 25 years and over with high school diploma or higher; number and percent of people living in poverty	Most environmental exposure, hazard, and health data on the Tracking Network are provided at the county level. Some data, where available, are provided at the census tract level. The National Environmental Public Health Tracking Program works closely with all data stewards and abides by their privacy and confidentiality guidelines	The years of data vary depending on the data source	Tracking Network (https://ephtracking.cdc.gov/) data are available in several formats: • Interactive maps, tables, and charts via the Data Explorer (https://ephtracking.cdc.gov/DataExplorer/#/) • Quick reports • An open Application Programming Interface (API) • Downloadable datasets. Data from the funded state and local Tracking Programs can also be accessed from the Tracking Network website	Customized reports can be generated through the Data Explorer. Quick reports (data tables) are also available on the Tracking Network website

Data Source: National Healthcare Safety Network (NHSN) (https://www.cdc.gov/nhsn/about-nhsn/index.html)

Brief Description: NHSN is a secure, Internet-based surveillance system, launched in 2005 by combining three legacy systems into a single platform developed and managed by the Division of Healthcare Quality Promotion (DHQP) at the Centers for Disease Control and Prevention (CDC). The system serves multiple users and uses. It enables CDC, healthcare facilities, and other public and private sector organizations to track, measure, and respond to adverse events and prevention opportunities in the realms of patient and healthcare worker safety. The prime surveillance targets for CDC and other organizations are HAIs, antimicrobial use and resistance (AUR), blood safety incidents, and healthcare worker vaccination coverage. Healthcare facilities use NHSN data for surveillance and benchmarking purposes. The Centers for Medicare and Medicaid Services' (CMS') public reporting and payment programs use HAI data submitted to NHSN for quality measurement purposes. State and local healthcare departments with reporting mandates or data use agreements with CDC gain access to NHSN data for use in surveillance and prevention programs. The NHSN platform is composed of six components—Patient Safety, Healthcare Personnel Safety, Biovigilance, Dialysis, Long-term Care, and Outpatient Procedure—with a seventh component—Neonatal—planned for future release. Each component is designed to serve a discrete community of end users, enabling their use of data submitted to a NHSN for timely analysis and focused action. For example, NHSN users in healthcare facilities gain immediate access to the data that their facility submits to the system, and they can analyze NHSN using built-in analytic features, including options designed to guide HAI prevention efforts.

Examination Components: Healthcare facility participation in NHSN has grown substantially, from approximately 300 hospitals when the system was launched to over 25,000 healthcare facilities currently. Participants include acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and nursing homes, with hospitals and dialysis facilities representing most facilities reporting data. Continued increases in facility participation are expected in the coming years as NHSN extends the scope of its surveillance coverage to additional adverse event types and new prevention opportunities in healthcare.

Table 41. National Healthcare Safety Network (NHSN)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients and healthcare workers in healthcare facilities throughout the United States, including acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and nursing homes, with hospitals and dialysis facilities representing most facilities reporting data	Date of birth and gender (M, F, other)	Race and ethnicity are optional	N/A	Facility-based reporting, to street address level	Ongoing since 2005	Healthcare facility-specific NHSN data that CDC reports on behalf of hospitals and other facilities to CMS can be accessed at the CMS Hospital Compare website: https://www.medicare.gov/hospitalcompare/search.html	Annual reports include the Antimicrobial Resistance Reports, National and State-specific Healthcare-Associated Infections Progress Reports, and additional NHSN reports and resources. Available here: https://www.cdc.gov/nhsn/datastat/index.html

Data Source: National HIV Behavioral Surveillance System (NHBS) (https://www.cdc.gov/hiv/statistics/systems/nhbs/index.html)

Brief Description: The NHBS system monitors the HIV epidemic through an ongoing HIV behavioral surveillance system to ascertain 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 non-injection 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. In addition, all sites conduct HIV testing of participants, with the option to conduct other related testing, including for sexually transmitted infections and Hepatitis C.

Table 42. National HIV Behavioral Surveillance System (NHBS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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)	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 and poverty index; education; occupation status; marital status; homelessness; incarceration; stigma; health insurance	22 Metropolitan statistical areas with high HIV prevalence: Atlanta, GA; Boston, MA; Chicago, IL; Dallas, TX; Denver, CO; Detroit, MI; Houston, TX; Los Angeles, CA; Miami, FL; Memphis, TN; Nassau-Suffolk, NY; New Orleans, LA; New York City, NY; Newark, NJ; Norfolk, VA; Philadelphia, PA; Portland, OR; San Diego, CA; San Francisco, CA; San Juan, PR; Seattle, WA; Washington, DC	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, MMWR

Data Source: National Immunization Survey-Child (NIS-Child) (https://www.cdc.gov/vaccines/imz-managers/nis/about.html)

Brief Description: The National Immunization Survey-Child (NIS-Child) is a continuing nationwide telephone sample survey to monitor coverage with all recommended vaccines among children aged 19-35 months living in the United States and selected U.S. territories. The NIS-Child has been conducted annually since 1994.

Examination Components: The first stage of survey administration involves telephone interviews with parents or guardians in households with age-eligible children. In the second stage, healthcare provider reports of vaccination information from the child's medical records are obtained.

Table 43. National Immunization Survey-Child (NIS-Child)

Target Population	Age/ Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children[3]	19-35 months/ males and females	non-Hispanic White, non-Hispanic Black, Hispanic, non-Hispanic American Indian/Alaska Native, non-Hispanic Asian, non-Hispanic Native Hawaiian or other Pacific Islander, non-Hispanic multiple races	Income-to-Poverty Ratio	Estimates are produced for the United States and selected U.S. territories (e.g., Guam, Puerto Rico, U.S. Virgin Islands) as well as non-overlapping geographic areas consisting of the 50 states, the District of Columbia, and selected large urban areas	1994-present	Datasets and related documentation available at https://www.cdc.gov/vaccines/imz-managers/nis/datasets.html	Publications available at https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/pubs-presentations.html

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[3] 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 Immunization Survey-Teen (NIS-Teen) (https://www.cdc.gov/vaccines/imz-managers/nis/about.html)

Brief Description: The National Immunization Survey-Teen (NIS-Teen) is a continuing nationwide telephone sample survey to monitor coverage with all recommended vaccines among adolescents aged 13-17 years living in the United States and selected U.S. territories. The NIS-Teen has been conducted annually since 2006.

Examination Components: The first stage of survey administration involves telephone interviews with parents or guardians in households with age-eligible adolescents. In the second stage, healthcare provider reports of vaccination information from the teen's medical records are obtained.

Table 44. National Immunization Survey-Teen (NIS-Teen)

Target Population	Age/ Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescents[4]	13-17 years/ males and females	non-Hispanic White, non-Hispanic Black, Hispanic, non-Hispanic American Indian/Alaska Native, non-Hispanic Asian, non-Hispanic Native Hawaiian or other Pacific Islander, non-Hispanic multiple races	Income-to-Poverty Ratio	Estimates are produced for the United States and selected U.S. territories (e.g., Guam, Puerto Rico, U.S. Virgin Islands) as well as non-overlapping geographic areas consisting of the 50 states, the District of Columbia, and sleeted large urban areas	2006-present (2006 and 2007 surveys include national data only)	Datasets and related documentation available at https://www.cdc.gov/vaccines/imz-managers/nis/datasets-teen.html	Publications available at https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/pubs-presentations.html

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[4] Vaccines currently included in the survey are: tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap); quadrivalent meningococcal conjugate vaccine (MenACWY); human papillomavirus (HPV); varicella vaccine; measles, mumps, and rubella vaccine (MMR); hepatitis B vaccine (HepB); and influenza vaccine

Data Source: National Intimate Partner and Sexual Violence Survey (NISVS) (https://www.cdc.gov/violenceprevention/datasources/nisvs/index.html)

Brief Description: NISVS is an ongoing survey that collects the most current and comprehensive national- and state-level data on intimate partner violence, sexual violence and stalking victimization in the United States. CDC developed NISVS to collect data on these important public health problems and enhance violence prevention efforts.

Examination Components: Random-digit-dial telephone survey of U.S. adults: victimization experiences of sexual violence, stalking, and intimate partner violence.

Table 45. National Intimate Partner and Sexual Violence Survey (NISVS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. non-institutionalized adult population	18+ / female, male, transgender	Hispanic; non-Hispanic Black; non-Hispanic White; non-Hispanic Asian or Pacific Islander; non-Hispanic American Indian or Alaska Native; Multiracial	Income; education	National and state levels	2010-2012, 2015, 2016-2018	Available at https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34305	Available at https://www.cdc.gov/violenceprevention/nisvs/index.html

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

Brief Description: 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 states, 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.

Table 46. National Notifiable Diseases Surveillance System (NNDSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	N/A	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 http://wwwn.cdc.gov/nndss/downloads.html	Tabulates and publishes these data in MMWR and in Summary of Notifiable Diseases

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

Brief Description: NORS is a web-based platform launched in 2009. It is used by local, state, and territorial health departments in the United States to report all foodborne and waterborne disease outbreaks, and enteric disease outbreaks transmitted by contact with environmental sources, infected persons or animals, or unknown modes of transmission.

Examination Components: NORS is a web-based platform for outbreak reporting. Through NORS, CDC collects reports of enteric disease outbreaks caused by bacterial, viral, parasitic, chemical, toxin, and unknown agents, as well as foodborne and waterborne outbreaks of non-enteric disease.

Table 47. National Outbreak Reporting System (NORS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. foodborne, waterborne, and enteric disease outbreaks	Number and percentage of cases age <1, 1-4, 5-9, 10-19, 20-49, 50-74, 75+. Number of and percentage of cases who are male, female, or of unknown sex	N/A	N/A	State or territory level	NORS data (all outbreaks, regardless of mode of transmission) are available from 2009-2017. Foodborne transmission data are available from 1973-2017, and waterborne from 1971-2017	NORS data are available at https://www.cdc.gov/norsdashboard. Historical waterborne (1971-2008) and foodborne (1973-1997) outbreak data are available by request	Publications and reports available at https://www.cdc.gov/nors/publications.html. The NORS Dashboard is available at: https://wwwn.cdc.gov/norsdashboard/

Data Source: National Program of Cancer Registries (NPCR) (http://www.cdc.gov/cancer/npcr/)

Brief Description: NPCR provides funds and guidance to states and United States territories to implement and enhance their cancer registries. As of 2018, NPCR supported central registries and promoted the use of registry data in 46 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.

Table 48. National Program of Cancer Registries (NPCR)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 (public use database); County (data visualization tool)	Since 1999	Data visualization tool is available at http://www.cdc.gov/cancer/dataviz Must request access to the public use dataset. Additional information at http://www.cdc.gov/cancer/public-use	Cancer data for the entire U.S. population are available at: http://www.cdc.gov/uscs

Data Source: National Survey of Adoptive Parents (NSAP) (http://www.cdc.gov/nchs/slaits/nsap.htm)

Brief Description: NSAP is the first large, nationally representative survey of adoptive families across adoption types. A secondary sample focuses on adopted children with special healthcare needs. The NSAP is conducted by CDC and is sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and 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 non-financial service utilization.

Table 49. National Survey of Adoptive Parents (NSAP)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 stepparent 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 healthcare 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 non-financial support	National	2007-2008	Available publicly at: http://www.cdc.gov/nchs/slaits/nsap.htm	A one-time report is available at: http://aspe.hhs.gov/hsp/09/NSAP/chartbook/index.cfm

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

Brief Description: NVDRS contains information on all homicides, suicides, deaths of undetermined intent (including opioid-related deaths of undetermined intent), legal intervention deaths, and unintentional firearm deaths.

Examination Components: Data from death certificates, coroner/medical examiner (C/ME) reports (includes toxicology reports), law enforcement reports.

Table 50. National Violent Death Reporting System (NVDRS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
NVDRS is currently in all 50 states, the District of Columbia, and Puerto Rico	All ages and all genders	All races/ethnicities	Occupation, education, and place of residence	NVDRS is currently in all 50 states, the District of Columbia, and Puerto Rico	2003-ongoing (most recent data year available is 2017)	NVDRS Restricted Access Database (RAD) is available for researchers; there are examples of how VDRS states have used data for suicide and homicide prevention; NVDRS data is used by CDC staff for scientific analyses, publications, Epi-Aids; Limited NVDRS data is available through Web-based Injury Statistics Query and Reporting System (WISQARS): https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jsp	MMWR Surveillance Summaries; for a list of some publications that use NVDRS data please visit: https://www.cdc.gov/violenceprevention/nvdrs/publications.html

Data Source: National Youth Fitness Survey (NNYFS) (http://www.cdc.gov/nchs/nnyfs.htm)

Brief Description: The NHANES National Youth Fitness Survey (NNYFS) was conducted in 2012 to collect data on physical activity and fitness levels in order to provide an evaluation of the health and fitness of children in the U.S. ages 3 to 15. The NNYFS collected data on physical activity and fitness levels of our youth through interviews and fitness tests.

Examination Components: Body measures; core, lower and upper body muscle strength; gross motor skills; physical activity monitor; aerobic fitness; physical activity questionnaire; dietary recall interview; computer-assisted self-interview.

Table 51. National Youth Fitness Survey (NNYFS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children	3-15 years	Non-Hispanic White, non-Hispanic Black, Mexican American	Family and total household income; poverty index; Head of household education	National	2012	Public Use Files, usable without restrictions	https://www.cdc.gov/nchs/data/series/sr_02/sr02_163.pdf

Data Source: National Youth Tobacco Survey (NYTS) (http://www.cdc.gov/tobacco/data_statistics/surveys/nyts/)

Brief Description: 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—Reduce the proportion of adolescents in grades 6–12 exposed to tobacco marketing on the Internet
- TU–18.2—Reduce the proportion of adolescents in grades 6–12 exposed to tobacco marketing in magazines and newspapers
- TU–18.3—Reduce the proportion of adolescents and young adults in grades 6 through 12 who are exposed to tobacco marketing in movies and television
- TU–18.4—Reduce the proportion of adolescents and young adults in grades 6 through 12 who are exposed to tobacco marketing at point of purchase (convenience store, supermarket, or gas station)

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.

Table 52. National Youth Tobacco Survey (NYTS)

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. students in grades 6 through 12	Males and females ages 11-18 years	American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White. Hispanic Ethnicity: Mexican; Mexican American, Chicano or Chicana; Puerto Rican; Cuban; Other Hispanic or Latino	Money to spend each week	National	1999 – 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 https://www.cdc.gov/tobacco/data_statistics/surveys/nyts/ https://www.cdc.gov/tobacco/data_statistics/index.htm

Data Source: Patient Safety Atlas: Inpatient Stewardship Programs (https://gis.cdc.gov/grasp/PSA/indexST.html)

Brief Description: The Inpatient Stewardship Programs Patient Safety Atlas presents data on inpatient antibiotic stewardship practices in U.S. acute care hospitals. Data is gathered on the seven Core Elements of Hospital Antibiotic Stewardship Programs:

1. Leadership Commitment: Dedicating necessary human, financial and IT resources.
2. Accountability: Appointing a single leader responsible for program outcomes.
3. Drug Expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.
4. Action: Implementing at least one recommended action.
5. Tracking: Monitoring antibiotic prescribing and resistance patterns.
6. Reporting: Regular reporting information on antibiotic use and resistance to doctors, nurses and relevant staff.
7. Education: Educating clinicians about resistance and optimal prescribing.

Examination Components: Healthcare facilities that participate in NHSN complete an annual online survey, which includes questions on facility demographics, laboratory practices, and infection control practices. Questions specific to antibiotic stewardship practices (ASPs)' organizational structure, support, and activities were first included in 2014. The survey is typically completed by the hospital's infection preventionists. However, hospital staff who complete the antibiotic stewardship questions are encouraged by CDC to request assistance from "pharmacists and/or physicians who focus on infectious diseases, where available, and/or members of the facility's pharmacy and therapeutics committee." The antibiotic stewardship portion of the survey has 12 questions (numbers 23 through 34). CDC used responses to these questions to assess whether each facility met the criteria for seven core elements of ASPs.

Table 53. Patient Safety Atlas: Inpatient Stewardship Programs

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Acute care hospitals	N/A	N/A	N/A	State	2014-2017	The Atlas can be accessed at: https://gis.cdc.gov/grasp/PSA/indexST.html	Reports on Antibiotic Stewardship Program Data can be found here: https://www.cdc.gov/antibiotic-use/healthcare/evidence.html

Data Source: Patient Safety Atlas: Outpatient Antibiotic Use (https://gis.cdc.gov/grasp/PSA/indexAU.html)

Brief Description: The National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS) (https://www.cdc.gov/nchs/ahcd/about_ahcd.htm) can be used to measure outpatient antibiotic prescribing and appropriateness in U.S. doctor's offices, emergency departments, and hospital-based clinics. The data source for the Atlas includes proprietary datasets from third-party vendors. For example, QuintilesIMS (formerly Intercontinental Medical Statistics (IMS) Health) Xponent database can be used to measure the number and rates of outpatient, oral antibiotics dispensed in U.S. community pharmacies. Quality measure data, such as Healthcare Effectiveness Data and Information Set (HEDIS), can be used to examine the quality of antibiotic prescribing by region and across health plans.

Examination Components: Reporting facilities are community pharmacies and mail order pharmacies. Federal healthcare facilities and pharmacies were not included. The national data includes 10 antibiotic classes; the state data includes common antibiotic classes, such as Penicillin (e.g., amoxicillin), Macrolides (e.g., azithromycin) and Fluoroquinolones (e.g., ciprofloxacin, levofloxacin).

Table 54. Patient Safety Atlas: Outpatient Antibiotic Use

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Oral antibiotic prescriptions dispensed to outpatients in U.S. community pharmacies	Age Category (0-19, 20+) Gender (M, F)	N/A	N/A	State	2011-2016	The Atlas can be accessed at: https://gis.cdc.gov/grasp/PSA/indexAU.html	Reports are available at: https://www.cdc.gov/antibiotic-use/community/programs-measurement/measuring-antibiotic-prescribing.html

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

Brief Description: The Perinatal Hepatitis B Prevention Program contains information on 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.

Table 55. Perinatal Hepatitis B Prevention Program

Target Population	Age	Race & Ethnicity	Socioeconomic 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 races and ethnicities	N/A	State, local, territorial	N/A	Viral hepatitis statistics and surveillance available at http://www.cdc.gov/hepatitis/statistics/index.htm	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 http://www.cdc.gov/hepatitis/partners/perihepbcoord.htm

Data Source: Pregnancy Mortality Surveillance System (PMSS) (https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpmss.html)

Brief Description: PMSS conducts national pregnancy-related mortality surveillance to better understand the risk factors for and causes of pregnancy-related deaths in the United States.

Examination Components: PMSS examines all pregnancy-related deaths in the United States. A pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy –regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Table 56. Pregnancy Mortality Surveillance System (PMSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Pregnant women who die within one year of the end of a pregnancy	Women of childbearing age	All races/ethnicities	Education	National	1986 – 2015	Pregnancy mortality surveillance data are protected under 308(d) Assurance of Confidentiality. Because of this Assurance, all data and documents are considered confidential materials and are safeguarded to the greatest extent possible. This Assurance extends to all pregnancy mortality surveillance data obtained from individual states and reporting areas	Information about causes of pregnancy-related deaths and risk factors associated with these deaths is released periodically through peer-reviewed literature, CDC's *MMWRs*, and the CDC Web site https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpmss.html

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

Brief Description: 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 states to use to inform programs and policies 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., prenatal care received, breastfeeding, smoking and drinking during pregnancy).

Table 57. Pregnancy Risk Assessment Monitoring System (PRAMS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Women with a recent live birth	Women of childbearing age	All races/ethnicities	Insurance, Income, education	State, cities or jurisdiction with independent Vital statistics reporting programs (NYC, DC) and territories (Puerto Rico)	Data availability starts in 1988 to 2017	Researchers may request data files by submitting a proposal to CDC. The information on the submission process is available at http://www.cdc.gov/prams/researchers.htm	Available at https://www.cdc.gov/prams/prams-data/mch-indicators.html

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

Brief Description: 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.

Table 58. School Health Policies and Practices Study (SHPPS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
State education agencies, public school districts, public and private K-12 schools, health education and physical education classes	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	N/A	N/A	Conducted at the state, district, school and classroom levels nationwide	SHPPS was conducted at varying levels in 1994, 2000, 2006, 2012, 2014, and 2016	Data files and documentation, including codebooks and questionnaires, are available for 2012, 2014, and 2016 at https://www.cdc.gov/healthyyouth/data/shpps/results.htm. To request data from previous cycles, a data request form is available at http://www.cdc.gov/healthyyouth/data/shpps/contact.htm	Available at http://www.cdc.gov/HealthyYouth/shpps/index.htm

Data Source: School Health Profiles (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 and physical activity, school health policies related to tobacco use prevention and nutrition, and family engagement and community involvement, and school health coordination.

Table 59. School Health Profiles

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	N/A	N/A	States, districts, territories, tribal government	Every two years since 1996	Profiles from surveys conducted since 1996, as well as item rationales for previous versions of Profiles questionnaires are available upon request. Form is available at http://www.cdc.gov/healthyyouth/data/profiles/contact.htm	2016 and previous School Health Profiles available at https://www.cdc.gov/healthyyouth/data/profiles/results.htm

Data Source: Sentinel Event Notification System for Occupational Risk (SENSOR) Pesticides Program (https://www.cdc.gov/niosh/topics/pesticides/overview.html)

Brief Description: SENSOR Pesticides Program is maintained by the National Institute for Occupational Safety and Health (NIOSH). SENSOR-Pesticides has been monitoring acute occupational pesticides-related illnesses and injuries using standardized definitions and variables since 1987. Under this program, CDC/NIOSH provides cooperative agreement funding and technical support to state health departments to conduct surveillance of acute pesticide-related illness and injury. Funding support is also provided by the EPA. In 2017, 13 states participated in this program. State SENSOR-Pesticide programs use multiple sources for case ascertainment, including poison control centers, workers' compensation documents, information from other government agencies, such as State Departments of Agriculture, physician reports, and other sources. Active case follow-up is performed either directly by the surveillance system or by state partner agencies.

Examination Components: Administrative and demographic data, industry and occupation for work-related cases, pesticide exposure information, health effects information, and investigation findings.

Table 60. Sentinel Event Notification System for Occupational Risk (SENSOR) Pesticides Program

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population in 13 participating states	All ages	Hispanic or not Hispanic. American Indian or Alaska Native; Asian or Pacific Islander; Black; White; Mixed Race; Other. (Information on ethnicity or race is available for about 1/3 of the cases)	Industry and occupation for work-related cases	State and county	Since 1987	Data collected since 1998 are available for selected variables at: https://wwwn.cdc.gov/Niosh-whc/chart/sensor-pe Data are also available via request through the Freedom of Information Act (FOIA)	MMWR and publications in peer-reviewed journals

Data Source: Sexually Transmitted Diseases Surveillance System (STDSS) (https://www.cdc.gov/std/stats/default.htm)

Brief Description: 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.

Table 61. Sexually Transmitted Diseases Surveillance System (STDSS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	All ages	All races and ethnicities	N/A	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 NCHHSTP Atlas available at http://www.cdc.gov/nchhstp/atlas/	2016 and other recent annual reports available at https://www.cdc.gov/std/stats/

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

Brief Description: The 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.

Table 62. State Tobacco Activities Tracking and Evaluation (STATE) System

Target Population	Age	Race & Ethnicity	Socioeconomic 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	A tobacco use data portal is available at https://chronicdata.cdc.gov/health-area/tobacco-use State highlights available at http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_STATE.Highlights&islLocation=US&rdDashboardTabs=HLR_QUI&rdRequestForwarding=Form	Customized reports available at http://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_State.CustomReports

Data Source: Universal Data Collection (UDC) System (https://www.cdc.gov/ncbddd/blooddisorders/udc/index.html)

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 UDC system. UDC is carried out with the help of federally funded 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.

Table 63. Universal Data Collection (UDC) System

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Patients with bleeding disorders	All ages	White; Black; Hispanic; Asian/Pacific Islander; American Indian/Alaska Native; Other	Education; health insurance	National, regional	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 (VAERS) (https://vaers.hhs.gov/data/index and http://wonder.cdc.gov/vaers.html)

Brief Description: 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, healthcare providers, vaccine manufacturers, state vaccine programs and other constituencies. VAERS datasets are available for download on the VAERS HHS website in csv file format. CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) provides an easy-to-use, menu-driven search tool accessible to the public for querying VAERS data. VAERS datasets are provided to HHS and CDC WONDER mid-month. The datasets include a short list of variables on primary reports received from 1990 to present day.

Examination Components: This reporting system examines vaccines, symptoms, doses, dates, places and more. VAERS contains information on unverified reports of adverse events (illnesses, health problems and/or symptoms) following immunization with U.S.-licensed vaccines. Reports are accepted from anyone and can be submitted electronically. Event characteristics include symptoms reported, vaccine type, name and manufacturer, number of days between vaccination and the adverse event, vaccination date, report date, whether the event was considered serious, how the event outcome was categorized, whether the patient recovered, and the patient's age group, sex and home state. The VAERS data are updated monthly and include reports processed in the previous month. On June 30, 2017, VAERS released a new reporting form, called the VAERS 2.0 Report Form. This new form replaced the now obsolete VAERS-1 Report Form, which was active from July 1, 1990 to June 29, 2017. Changes include addition of new data elements, revisions to existing data elements, and elimination of some older data elements.

Table 64. Vaccine Adverse Event Reporting System (VAERS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Anyone who has experienced a clinically significant event that occurs after the administration of any vaccine licensed in the U.S.	All ages (measured by years and months), gender	N/A	N/A	State	1990-present. Data is posted approximately 15th every month	Datasets are available to download at https://vaers.hhs.gov/data.html and to search at https://wonder.cdc.gov/vaers.html	Publications: https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/publications.html Information on State and Territorial Immunization Programs available at https://vaers.hhs.gov/

Data Source: Vaccine Safety Datalink (VSD) Project (https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/index.html)

Brief Description: VSD is a collaborative project between CDC's Immunization Safety Office within the National Center for Emerging and Zoonotic Infectious Diseases (Division of Healthcare Quality and Promotion) and eight healthcare 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. Datasets from two studies are available: "Infant and Environmental Exposures to Thimerosal and Neuropsychological Outcomes at Ages 7 to 10 Years" (published September 2007) and "Prenatal and Infant Exposure to Thimerosal from Vaccines and Immunoglobins and Risk of Autism" (published October 2010). Rapid Cycle Analysis (RCA) allows VSD to detect adverse events following vaccination in near real time so the public can be informed quickly of possible risks. Using VSD data that are updated each week, the rates of adverse events that occur in people who have received a particular vaccine are compared to the rate of adverse events that occurs in a similar group of people who have not received that vaccine.

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 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.

Table 65. Vaccine Safety Datalink (VSD) Project

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Infants, children and adults receiving care at nine nationwide healthcare organizations	Age (birthdate): youth cohort and adult cohort, male/female/unknown. Source: codebook: https://www.cdc.gov/vaccinesafety/pdf/vsd-data.pdf	White, Black, Asian, Hawaiian or Another Pacific Islander, Native American or Aleutian, Hispanic, Other Race	Census tract information; for datasets drawn from the VSD some additional variables may be available (maternal education, ratio of household income-to-poverty line, single parent household)	Healthcare organization (one of nine, nationwide) – Group Health Cooperative of Puget Sound, Seattle, Washington; Harvard Pilgrim Health Care, Boston, Massachusetts; HealthPartners Research Foundation, Minneapolis, Minnesota; Kaiser Permanente Northwest, Portland, Oregon; Kaiser Permanente Medical Care Program of Northern California, Oakland, California; Kaiser Permanente Colorado, Denver, Colorado; Kaiser Permanente of Georgia, Atlanta, GA; Marshfield Clinic Research Foundation, Marshfield, Wisconsin; Southern California Kaiser Permanente Health Care Program, Los Angeles, California	1990 – present	Depending on the study, interested researchers may be able to access VSD data and data from VSD publications through public use datasets, the VSD data sharing program, and collaboration with current VSD investigators. Interested researchers may learn more about each study through the study documents and reports as well as data files for additional analyses. For more information: http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/accessing-data.html. Requests to access the public use datasets can be sent to mailto:publicdataset@cdc.gov	Information for healthcare providers available at http://www.cdc.gov/vaccinesafety/hcproviders/index.html Information for parents and caregivers, http://www.cdc.gov/vaccinesafety/caregivers/index.html

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

Brief Description: The CDC 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, healthcare 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.

Table 66. Wide-ranging Online Data for Epidemiologic Research (WONDER)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
N/A	N/A	N/A	N/A	N/A	N/A	Information can be retrieved by systems or by topic, and an alphabetical list is also provided at http://wonder.cdc.gov/Welcome.html Data user restrictions information available at http://wonder.cdc.gov/datause.html	Information on what is new in CDC WONDER is made available on a timely basis at http://wonder.cdc.gov/WhatsNew.html

Data Source: Youth Risk Behavior Surveillance System (YRBSS) (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm?s_cid=tw-zaza-1171)

Brief Description: YRBSS was developed in 1990 to monitor health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include:

- Behaviors that contribute to the unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

Examination Components: The YRBSS includes national, state, territorial, tribal government, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States. The state, territorial, tribal government, and local surveys, conducted by departments of health and education, provide data representative of mostly public high school students in each jurisdiction.

Table 67. Youth Risk Behavior Surveillance System (YRBSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
9th through 12th grade students in public, Catholic, and private schools in the U.S.	Information available	White; Black/African American; AI/AN; Asian; Native Hawaiians and Pacific Islander (NHPI); Hispanic	N/A	National, State, Territorial, Local	1991-2017	Available	No reports

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention
National Center for Health Statistics

Overview of the National Center for Health Statistics (NCHS) Data Linkage Program

NCHS is the nation's principal health statistics agency, providing data to identify and address health issues. NCHS compiles statistical information to help guide public health and health policy decisions. Collaborating with other public and private health partners, NCHS uses a variety of data collection mechanisms to obtain accurate information from multiple sources. This process provides a broad perspective to help understand the population's health, influences on health, and health outcomes.

The NCHS Data Linkage Program is designed to maximize the scientific value of the Center's population-based surveys by linking data from health surveys with data from vital and administrative records. Linked data files enable researchers to examine factors that influence disability, chronic disease, healthcare utilization, and mortality. Linked data files also maximize scientific value by creating an efficient means to expand the analytic potential of both the survey and administrative data, thereby enabling analyses that would not be possible with either data source alone.

What NCHS surveys are linked to administrative data sources?

NCHS survey data used in linkages include:

- National Health Interview Survey (NHIS)
  - NHIS monitors a broad range of health topics with data collected through personal household interviews.
- National Health and Nutrition Examination Survey (NHANES)
  - NHANES is designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations.
- National Health Care Surveys
  - The National Health Care Surveys are designed to answer key questions on the use and quality of healthcare services, including safety and disparities in care provided to population subgroups.

What administrative data sources are linked to NCHS surveys?

Vital and administrative data sources include:

- **National Death Index**
  - State vital statistics offices provide records for this centralized database on deaths in the United States. Mortality information include date and cause of death information.
- **Centers for Medicare and Medicaid Services (CMS) Medicare enrollment and claims data, Medicaid Analytic eXtract data**
  - CMS provides health insurance and healthcare coverage for people age 65 and older and some vulnerable populations in the United States, including low-income children and the aged or disabled.
- **Housing and Urban Development (HUD)**
  - HUD is responsible for overseeing and managing domestic housing programs and policies, including specialized programs for high-needs United States populations (e.g., the elderly, homeless, and disabled)**.**
- **Social Security Administration (SSA)**
  - SSA administers retirement and disability benefits for elderly and disabled populations in the United States.

The full list of surveys and linked data can be found at this link: https://www.cdc.gov/nchs/data/datalinkage/LinkageTable.pdf

How can researchers get access to the linked data?

To protect confidentiality of survey participants, restricted files can be accessed only through the NCHS Research Data Centers or Federal Statistical Research Data Centers. Public use feasibility files, containing a limited set of variables to determine the maximum available sample size for select linked files, are available on the data linkage website.

The NCHS linked mortality files are available as both public use and restricted-use files. Public use linked mortality files contain limited information on cause of death and are available on the data linkage website. The public use versions of the NCHS Linked Mortality Files were subjected to data perturbation techniques to reduce the risk of participant re-identification. For selected decedent records, synthetic data were substituted for the actual date and underlying cause of death. Information regarding vital status was not perturbed. The restricted-use linked mortality files are not perturbed and contain detailed information on date and cause of death.

Where can researchers learn how to analyze the linked data?

Detailed methods report and analytic guidance documentation are published on the NCHS website for all NCHS linked data files. These documents provide information on data sources, linkage methodology, and analytic considerations, including guidance on using sample weights and additional information on key variables of analytic interest. NCHS has also created a tutorial for the NHANES-CMS linked data to help researchers navigate analytic approaches when using these linked data.[5]

What research questions can be answered using the linked data?

Currently, the NCHS Data Linkage Program brings together national population health and healthcare provider survey data with administrative data sources covering mortality, healthcare utilization and costs, retirement and disability insurance, and federal housing assistance. The NCHS linked data files have been used to conduct innovative research projects that could not be conducted on either data source on its own.

Some recent examples include:

- Deaths associated with underweight, overweight, and obesity (Flegal et al. 2007)
- Air pollution exposure and heart disease mortality (Parker et al. 2017)
- Characteristics of those who chose Medicare Advantage upon Medicare enrollment at age 65 (Miller et al. 2016)
- Concordance between survey reported childhood asthma and linked Medicaid (Zablotsky et al. 2018)
- Housing assistance and blood lead levels (Ahrens et al. 2016)
- Cigarette smoking and adverse health outcomes among adults receiving federal housing assistance (Helms et al. 2017)

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[5] https://www.cdc.gov/nchs/tutorials/NHANES-CMS/index.htm

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

Brief Description: LSOA is a multicohort study designed to measure change in health status, health-related behaviors and healthcare, 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 healthcare 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 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. The 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; 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, healthcare utilization, unmet healthcare 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 unique 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)

Table 68. Longitudinal Studies of Aging (LSOA)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Elderly Americans (1) The Supplement on Aging (SOA) was conducted as part of the 1984 NHIS. The SOA was based on a national sample of 16,148 persons, 55 years of age and older, living in the community. (2) The 1984 SOA served as the baseline for the 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. (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. (4) The SOA II provides the baseline for the Second LSOA II). The LSOA II is a prospective study with a nationally representative sample comprised of 9,447 civilian non-institutionalized persons 70 years of age and over at the time of their SOA II interview.	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 [6]	National	1984-2000	1984 SOA: http://www.cdc.gov/nchs/lsoa/soa1.htm#data 1984-1990 LSOA, 1994 SOA II, and 1994-2000 LSOA II: Available upon request; to request a copy of the CD-ROM or diskettes, email: nchsquery@cdc.gov or telephone (301) 458-INFO	1984 SOA: http://www.cdc.gov/nchs/data/series/sr_01/sr01_021.pdf 1984-1990 LSOA: http://www.cdc.gov/nchs/data/series/sr_01/sr01_028.pdf 1994 SOA II and 1994-2000 LSOA II: None

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[6] 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: National Ambulatory Medical Care Survey (NAMCS) (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: NAMCS is a national survey designed to meet the need for objective, reliable information about the provision and use of ambulatory medical care services in the United States. NAMCS data are used to provide statistics that describe the characteristics of office visits to office-based physicians and Composite Health Care System (CHCs). These include patient demographic characteristics, the conditions most often treated, and the diagnostic and therapeutic services rendered, including medication prescribed.

Examination Components: This survey conducted annually is based on a sample of visits to non-federally employed office-based physicians who are primarily engaged in direct patient care. Physicians in the specialties of anesthesiology, pathology, and radiology are excluded from the survey. Data are obtained on patient characteristics, such as age, sex, race, and ethnicity, and visit characteristics, such as patient's reason for visit, physician's diagnosis, services ordered or provided, and treatments, including medication therapy. In addition, data about the physician and his or her practice characteristics are collected as part of a survey induction interview. Data on visits by patients who use opioids are collected for the following variables: up to five reasons for the visit, up to five diagnoses, up to 30 medications ordered, supplied, administered, or continued at this visit, and services provided regarding health education/counseling for substance abuse.

Table 69. National Ambulatory Medical Care Survey (NAMCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nationally representative survey of office-based physicians and CHC physicians and non-physician clinicians (physician assistants [PAs], nurse practitioners [NPs], and nurse midwives) currently providing ambulatory care, and the patient visits to these providers	Information available	For patient visit data: Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	None for patient	From 2012-2015 census division and state estimates for varying number of states All other years, Region: Northeast; Midwest; South; West	1973-1981; 1985; 1989-present	Public use microdata files or files available at the NCHS Research Data Center (RDC)	Annual

Data Source: National Electronic Health Records Survey (NEHRS), formerly the National Ambulatory Medical Care Survey Electronic Medical Records Supplement (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: The National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records (EMR) supplement began in 2008. It was a mixed-mode survey using mail and computer-assisted interview. The EMR survey was designed to collect information on the use of EMR systems and the availability of specific computerized functionalities in non-federal physician offices who are primarily engaged in ambulatory care. In 2008 and 2009, the survey shared the same sampling files as the in-person NAMCS. Like NAMCS, physicians in the specialties of anesthesiology, pathology, and radiology are excluded from the survey. Starting in 2010, the EMR survey sample size was expanded to provide state-level estimates for the 50 states and the District of Columbia. The EMR supplement became an independent survey, NEHRS, in 2012. The purpose of the survey was no longer to collect data solely on electronic health record adoption and capabilities, but also on the progress that office-based physicians have been making toward meeting the policy goals of the Health Information Technology for Economic and Clinical Health (HITECH) Act, and (in more recent years) progress toward the Promoting Interoperability programs and measuring the burden associated with electronic health records (EHRs). Beginning in 2015, NEHRS administered a web self-administered questionnaire in addition to the mail questionnaire, and computer-assisted telephone interviews.

Examination Components: Non-federally employed office-based physician survey of EHR adoption, EHR use, office practices, physician burden and attitudes about EHRs, and use of health information exchange; it also collects information on physician specialty and practice characteristics, including practice size and ownership.

Table 70. National Electronic Health Records Survey (NEHRS), formerly the National Ambulatory Medical Care Survey Electronic Medical Records Supplement

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Non-federally employed Office-based Physicians	Adults (25 years to 64) and older adults (65 years and older)	N/A	Median household income, percent of population where income is below poverty	National 2008-2009, States 2010-2017	2008-2011 (as NAMCS EMR), 2012-2015, 2017 (as NEHRS)	Information available at: https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm Restricted data available at: Research Data Center website: https://www.cdc.gov/rdc/	Available

Data Source: National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records Supplement– Physician Workflow Survey (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: The NAMCS Physician Workflow Supplement was a 3-year follow-up data collection initiative, of the 2011 NAMCS EMR supplement. It was 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 EHRs. More specifically, the supplement was designed to provide insight on where resources were needed to help physicians achieve Stage I and State II meaningful use of certified EHR technology goals, where Stage I focused on data capturing and sharing, while Stage II focused on advanced clinical processes.

Examination Components: Non-federally employed office-based physician survey that collected provider characteristics, use of electronic medical records and features, specialty, practice size, ownership, facility characteristics, physician's attitudes about EHRs, barriers, benefits and impact.

Table 71. National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records Supplement– Physician Workflow Survey

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
5,266 non-federally employed office-based physicians eligible for the 2011 NAMCS EMR supplement	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-	Median household income, percent of population where income is below poverty	State	2011-2013	Information available at: https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm Restricted data available at: Research Data Center website: https://www.cdc.gov/rdc/	Available as summary statistics

Data Source: National Death Index (NDI) (https://www.cdc.gov/nchs/ndi/index.htm)

Brief Description: NDI is a centralized database of death record information from state vital statistics offices.

Examination Components: NDI, a self-supporting service of NCHS, is a component of the National Vital Statistics System. NDI is a centralized database of death record information compiled from state and territorial death certificates.

Table 72. National Death Index (NDI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	Information available	White; Black/African American; Indian; Chinese; Japanese; Hawaiian; Other non-White; Filipino; Other Asian or Pacific Islander	N/A	State of residence/birth	1979-2018	The fees for NDI searches consist of a $350.00/$100.00 service charge plus a per record charge dependent of the type of search requested	N/A

Data Source: National Health Interview Survey (NHIS) (https://www.cdc.gov/nchs/nhis/index.htm)

Brief Description: NHIS data on a broad range of health topics are collected through personal household interviews. For over 50 years, the U.S. Census Bureau has been the data collection agent for the National Health Interview Survey. Survey results have been instrumental in providing data to track health status, healthcare access, and progress toward achieving national health objectives.

Examination Components: The National Health Interview Survey is a cross-sectional household interview survey. NHIS interviews are conducted throughout each year from January to December. The sample design is a probability-based design that results in nationally representative estimates from a sample of households and certain non-institutional group quarters. The current sample design was implemented in 2016 and is based on data from housing unit counts from the 2010 census. Sample areas were reselected to consider changes in the distribution of the U.S. population since 2006, when the previous sample design was first implemented. Commercial address lists were used as the main source of addresses, rather than field listing; and due to changes in population distributions, the sample design no longer needs to include an oversample of Black, Hispanic, and Asian persons.

The current sample design consists of a sample of over 300 clusters of addresses that are in well-defined geographic areas. These geographic areas consist of a county, a small group of contiguous counties, or a metropolitan area, located within the boundaries of a single state. As of the beginning of 2018, the NHIS sampling frame consists of two non-overlapping parts: the unit frame (a list of addresses purchased from a vendor), and the area frame (counties that do not have city-style addresses, and counties where the unit frame was not considered to be a sufficient sampling resource). The college dormitory sampling frame implemented in 2016–2017 was discontinued in 2018. The total NHIS sample is subdivided into four separate panels such that each panel is representative of the U.S. civilian non-institutionalized population (as is any combination of the four panels). This design feature has several advantages, including flexibility for the total sample size. For example, it allows for sample size reductions while retaining representativeness. The expected NHIS sample size (completed interviews) is approximately 35,000 households.

Table 73. National Health Interview Survey (NHIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Households (35,000 households per year)	Information available	White; Black/African American; Indian (American); Chinese; Filipino; Asian Indian; Other race; Multiple race; Hispanic (Detailed Hispanic group information)	Family and individual income; poverty level, type of living quarters, education, occupation, utilization of healthcare, health insurance, access to care	The current sampling plan is a sample of clusters of addresses that are in well-defined geographic areas. These geographic areas consist of a county, a small group of contiguous counties, or a metropolitan area	1957-present	Available	Annual

Data Source: National Health and Nutrition Examination Survey (NHANES) (https://wwwn.cdc.gov/nchs/nhanes/Default.aspx)

Brief Description: NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. NHANES is a major program of NCHS. NCHS is part of the Centers for Disease Control and Prevention (CDC) and has the responsibility for producing vital and health statistics for the Nation.

Examination Components: NHANES is a nationally representative survey of the resident civilian non-institutionalized U.S. population. Since 1999, about 5,000 persons are examined each year from about 15 counties across the country. The NHANES interview includes demographic, socioeconomic, dietary, and health-related questions. The examination component consists of medical, dental, and physiological measurements, as well as laboratory tests administered by highly trained medical personnel. Health interviews are conducted in respondents' homes and data are collected electronically.

Table 74. National Health and Nutrition Examination Survey (NHANES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Resident, non-institutionalized U.S. population of all ages (since 1999 examined sample is about 5,000 persons per year)	Information available	Non-Hispanic Black or African American; Non-Hispanic White; Mexican American since 1999 and all Hispanic groups since 2007; Asian (since 2011)	Income and poverty index; education; occupation; 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)	Available	Continuous, with capability for longitudinal follow-up

Data Source: National Home Health Aide Survey (NHHAS) (https://www.cdc.gov/nchs/nhhcs/nhhas.htm)

Brief Description: The 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 and conducted by the National Center for Health Statistics. 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. Aided in activities of daily living, including bathing, dressing, transferring, eating and toileting.

Examination Components: NHHAS was administered to aides during their non-working 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).

Table 75. National Home Health Aide Survey (NHHAS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Home health aides directly employed by home health, hospice, or mixed agencies (not contractors), and aiding with activities of daily living (ADLs), including bathing, dressing, transferring, eating, and toileting	All ages. Male, Female	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	Metropolitan Statistical Area (MSA)	2007	Some variables available on Public Use File: https://www.cdc.gov/nchs/nhhcs/nhhas.htm	2007 summary report: http://www.cdc.gov/nchs/data/nhsr/nhsr034.pdf

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

Brief Description: NHHCS is a series of nationally representative sample surveys of United States home health and hospice agencies, their services, their staff, and their patients. Of the 1,545 sampled agencies, 1,036 participated in the 2007 NHHCS and provided data on 9,416 current home health patients and hospice discharges from these agencies.

Examination Components: The survey was administered in sampled home health and hospice agencies using a computer-assisted personal interviewing (CAPI) system. A self-administered staffing questionnaire was mailed to the administrator, along with the appointment confirmation letter, to be completed by the time of the facility interview. Agency data collected, available in agency administrative records, included information on the year an agency was established, the types of services an agency provided, referral sources, specialty programs, and staffing characteristics. Data collected on 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.

Table 76. National Home and Hospice Care Survey (NHHCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Agencies that were certified by Medicare or Medicaid or were licensed by a State to provide home health and/or hospice services and currently or recently served home health and/or hospice patients. Agencies that provided only homemaker services or housekeeping services, assistance with instrumental activities of daily living (IADLs), or durable medical equipment and supplies were excluded	All ages. Male, Female	Hispanic; White; African American/ Black; American Indian/Alaska Native; Asian; Native Hawaiian/ Pacific Islander; Other	Payment source	Metropolitan Statistical Area (MSA)	The NHHCS was first conducted in 1992 and was repeated in 1993, 1994, 1996, 1998 and 2000, and most recently in 2007.	Data files available at: http://www.cdc.gov/nchs/nhhcs/nhhcs_questionnaires.htm	2007 patient and agency tables: https://www.cdc.gov/nchs/nhhcs/nhhcs_products.htm

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS) (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: NHAMCS is designed to collect data on the utilization and provision of ambulatory care services in hospital emergency and outpatient departments, and in ambulatory surgery centers.

Examination Components: This survey conducted annually is based on a national sample of visits to emergency departments (EDs), outpatient departments (OPDs), and ambulatory surgery locations (ASLs) in non-institutional general and short-stay hospitals, exclusive of federal, military, and Veterans Administration hospitals. Starting in 2018, only visits to EDs are included. Data are obtained on patient characteristics, such as age, sex, race, and ethnicity, and visit characteristics, such as patient's reason for visit, provider's diagnosis, services ordered or provided, and treatments, including medication therapy.

Data on visits by patients who use opioids are collected for the following variables: up to five reasons for the visit, up to five diagnoses, type of visit (visit involving injury/trauma), up to 30 medications given in the ED or prescribed at discharge.

Table 77. National Hospital Ambulatory Medical Care Survey (NHAMCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Hospitals within the 50 states and Washington, DC; Patient data collected	Information available	For patient visit data: Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	N/A	Region: Northeast; Midwest; South; West	1992-present	Public use microdata files or files available at the NCHS Research Data Center (RDC)	Annual

Data Source: National Hospital Care Survey (NHCS) (https://www.cdc.gov/nchs/nhcs/index.htm)

Brief Description: NHCS is designed to provide accurate and reliable healthcare statistics that answer key questions of interest to healthcare and public health professionals, researchers, and healthcare policy makers. This includes tracking the latest trends affecting hospitals and healthcare organizations and factors that influence the use of healthcare resources, the quality of healthcare, and disparities in healthcare services provided to population subgroups in the United States.7

Examination Components: NHCS integrates inpatient data formerly collected by the National Hospital Discharge Survey (NHDS), Emergency Department (ED), and outpatient department (OPD) data collected by the National Hospital Ambulatory Medical Care Survey (NHAMCS). The integration of these two surveys allows examination of care provided across treatment settings. It will also be possible to link these survey data to outside data sources, such as the National Death Index, to obtain a more complete picture of patient care.

Data collected based on ambulatory care and inpatient diagnoses and procedures data, including, but not limited to: Hospital discharges, average length of stay/days of care, first-listed diagnoses, patient characteristics, procedures, hospital inpatient deaths, discharge status, expected source of payment, Intensive Care Unit (ICU) stay, delivery and newborn information, detailed diagnoses and procedures.

Table 78. National Hospital Care Survey (NHCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Hospitals; Patient data collected	Information available	Limited data on White; Black/African American; AI/AN; Asian; NHPI; Hispanic. Race and Hispanic origin are often not provided by participating hospitals	NHCS monitors national trends in substance use-related ED visits, including opioid visits. Researchers can link these survey data to outside data sources, such as the National Death Index and Medicare data, to obtain a more complete picture of patient care	Region: Northeast; Midwest; South; West	2011-present	Data from 2013 through 2016 are available in the NCHS Research Data Center (https://www.cdc.gov/rdc/b1datatype/Dt1224h.htm). Data from the 2014 and 2016 NHCS have been successfully linked to the NDI and are now available to researchers through the NCHS Research Data Center. The 2014 NHCS has also been linked to the CMS Medicare Master Beneficiary Summary File and is available in the NCHS Research Data Center.	N/A

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[7] [integrates data from several databases, including, NHDS (data collected from: 1965-2010), and NHAMCS (1973-present). Linked data for 2014 and 2016 includes National Death Index (NDI)]; NHDS: National Hospital Discharge Survey; NHAMCS: See National Hospital Ambulatory Medical Care Survey.

Data Source: National Hospital Discharge Survey (NHDS) (https://www.cdc.gov/nchs/nhds/index.htm [collection ended in 2010, integrated into National Hospital Care Survey])

Brief Description: NHDS, which was conducted annually, was a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-federal short-stay hospitals.

Examination Components: Data collected based on inpatient diagnoses and procedures data including but not limited to: Hospital discharges, average length of stay/days of care, first-listed diagnoses, patient characteristics, procedures, hospital inpatient deaths, expected source of payment, delivery and newborn information, detailed diagnoses and procedures.

Table 79. National Hospital Discharge Survey (NHDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Hospitals; Patient data collected	Information available	White; Black/African American; AI/AN; Asian; NHPI; Hispanic	Source of payment	Region: Northeast; Midwest; South; West	1965-2010	Publications, Selected Tables and Reports Available; Datasets and documentation (1979-2010) available at https://www.cdc.gov/nchs/nhds/nhds_questionnaires.htm ; for data 2011-present see National Hospital Care Survey	N/A

Data Source: National Nursing Assistant Survey (NNAS) (https://www.cdc.gov/nchs/nnhs/nnas.htm)

Brief Description: NNAS is the first national study of nursing assistants working in nursing facilities in the United States. The U.S. Department of Health and Human Services sponsored the study. The NNAS looked at the important role of nursing assistants in providing long-term care services for the growing elderly and chronically ill population.

Examination Components: Data were collected through telephone interviews using a computer-assisted personal interviewing (CAPI) system, with a sample of workers who provide nursing home residents with assistance in Activities of Daily Living (ADLs) (eating, transferring, toileting, dressing and bathing). The survey included information on whether workers plan to continue working in their present positions and what factors affect their decisions, including job satisfaction, nature of the work environment, training, advancement opportunities, benefits, working conditions, and personal or family demands. The survey will help identify nursing assistants' priorities, ways to meet those priorities, and how to prevent staffing shortages in the future.

Examination Components: Survey of nursing assistants.

Table 80. National Nursing Assistant Survey (NNAS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
4,542 nursing assistants; nursing home employees (not contractors) who provided nursing home residents with assistance in ADLs (eating, transferring, toileting, dressing and bathing), certified (or in the process of certification to provide Medicare/Medicaid reimbursable services, and worked at least 16 hours per week	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 https://www.cdc.gov/nchs/nnhs/nnas.htm	Nursing assistant tables 2004-2005 available at http://www.cdc.gov/nchs/nnhs/nursing_assistant_tables.htm

Data Source: National Nursing Home Survey (NNHS) (https://www.cdc.gov/nchs/nnhs/index.htm)

Brief Description: NNHS is a series of nationally representative sample surveys of United States nursing homes, their services, their staff, and their residents. Of the 1,500 sampled nursing homes, 1,174 completed survey and provided data on 13,507 residents.

Examination Components: The survey was administered in sampled nursing home facilities using a computer-assisted personal interviewing (CAPI) system. A self-administered staffing questionnaire was mailed to the nursing home administrator, along with the appointment confirmation letter, to be completed by the time of the facility interview. Core components provided some common basic information about nursing homes, their residents, and their staff. The Facility Component of the CAPI included facility qualifications and facility characteristics data items. The resident data items included: Health Status (HA), Non-Minimum Data Set (HN), Prescribed Medications (PM), and Payment Sources (PA).

Table 81. National Nursing Home Survey (NNHS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nursing homes that had at least three beds and were either certified (by Medicare or Medicaid) or had a state license to operate as a nursing home	Residents of all ages. Male, Female	Hispanic; White; African American or Black; American Indian or Alaska Native; Asian; Native Hawaiian or Pacific Islander; Other	Payment source	Metropolitan Statistical Area (MSA)	The NNHS was first conducted in 1973-1974 and repeated in 1977, 1985, 1995, 1997, 1999, and most recently in 2004	Data files available at: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NNHS/nnhs04	2004 Resident tables: https://www.cdc.gov/nchs/nnhs/resident_tables.htm 2004 facility tables: https://www.cdc.gov/nchs/nnhs/facility_tables.htm

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

Brief Description: The biennial NSLTCP is a groundbreaking initiative to monitor trends in the supply, provision and use of the major sectors of paid, regulated post-acute and long-term care services. NSLTCP uses data from surveys of assisted living and similar 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. In 2016, of the 11,688 residential care communities sampled, 4,578 participated; of 5,348 adult day services centers, 2,836 participated. Beginning with the 2017-2018 wave, NSLTCP plans to add inpatient rehabilitation facilities and long-term care hospitals. The 2012-2016 waves collected data on services users summed at the provider level as summary measures, while the 2018 wave collected data on individual services users.

Examination Components: NSLTCP comprises two components: (1) primary data collected by 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. Data items include provider characteristics and services user characteristics.

Table 82. National Study of Long-Term Care Providers (NSLTCP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
For the residential care survey, the same definition was used as in the National Survey of Residential Care Facilities. Adult day services center were eligible if they were included in the National Adult Day Services Association's database and in operation as of November, 2015; had been licensed or certified by the state specifically to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), or authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care), or part of a Program of All-Inclusive Care for the Elderly (PACE); had an average daily attendance of one or more participants based on a typical week; and (d) had one or more participants enrolled at the center at the designated location at the time of the survey	Service Users were sampled in 2018; summary characteristics were collected for all services users in 2012-2016	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	N/A	State	2012, 2014, 2016, 2018	2012-2016 Datasets are available at Research Data Center locations at http://www.cdc.gov/nchs/nsltcp/nsltcp_questionnaires.htm Research Data Center website: http://www.cdc.gov/rdc/	NSLTCP 2015-2016 national reports: https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf https://www.cdc.gov/nchs/products/databriefs/db296.htm https://www.cdc.gov/nchs/products/databriefs/db299.htm NSLTCP 2013-2014 state tables: https://www.cdc.gov/nchs/data/nsltcp/2014_nsltcp_state_tables.pdf Other NSLTCP findings: https://www.cdc.gov/nchs/nsltcp/nsltcp_products.htm

Data Source: National Survey of Family Growth (NSFG) (https://www.cdc.gov/nchs/nsfg/index.htm)

Brief Description: NSFG gathers information on fertility, family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. The survey results are used by the U.S. Department of Health and Human Services and others to help plan health services and health education programs, and to do statistical studies of fertility, family formation, and sexual/reproductive health.

Examination Components: The survey sample is designed to produce national data, not estimates for individual states, representative of the household population of reproductive-age men and women in the U.S. NSFG is conducted through in-person interview, with a portion of the more sensitive questions answered privately by self-administration. No clinical or examination data are collected from survey participants. Only one survey participant is selected from each sample household. The interviews are voluntary and confidential, with informed consent procedures approved by the NCHS Ethics Review Board. For minor-age survey participants, parental consent is obtained in addition to the minor's assent. The response rate for recent NSFG data releases is around 70 percent.

Table 83. National Survey of Family Growth (NSFG)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
5,000 men and women interviewed each year, 15-44 of age, 15-49 since Sept 2015	Information available	White; Black/African American; Hispanic (including four additional groups); AI/AN; Asian, only available through and agreement with Research Data Center	Income and poverty index; education; employment status (full-time & part-time); source of payment for delivery & selected health services; receipt of public assistance	Only national estimates possible with public use data; estimates for four broad census regions possible using REGION recode available in the Research Data Center (RDC)	1973-2002 (6 cycles of periodic surveys); Continuous field work design since 2006; 1973-1995 surveys included only women; 2002 survey and 2006-onwards included men and women	Available	Continuous since 2006 (with break in data collection Jun 2010 –Sept 2011 to award new contract)

Data Source: National Survey of Residential Care Facilities (NSRCF) (https://www.cdc.gov/nchs/nsrcf/index.htm)

Brief Description: 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. Of 3605 sampled residential care facilities, 2302 completed the survey and provided information on 8094 residents.

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.

Table 84. National Survey of Residential Care Facilities (NSRCF)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Residential care facilities that are licensed, registered, listed, certified, or otherwise regulated by the state; have four or more licensed, certified, or registered beds; provide room and board with at least two meals a day and around-the-clock onsite supervision; and help with personal care, such as bathing and dressing or health-related services, such as medication management; serve predominantly adult population; and have at least one current resident. Excluded are places that are licensed to serve the severely mentally ill or the developmentally disabled populations exclusively and nursing homes, unless they have a unit or wing meeting the above definition and residents can be separately enumerated	Residents of all ages. Male, Female	Hispanic; White; African American or Black; American Indian or Alaska Native; Asian; Native Hawaiian or Pacific Islander; Other	Education; Medicaid use	Census Region	2010 (one – time survey)	Public Use Files available at: http://www.cdc.gov/nchs/nsrcf/nsrcf_questionnaires.htm	Available as summary statistics; 2012-2013 Publications and products available at http://www.cdc.gov/nchs/nsrcf/nsrcf_products.htm

Data Source: National Vital Statistics System (NVSS) (https://www.cdc.gov/nchs/nvss/index.htm)

Brief Description: NVSS is an inter-governmental system of sharing data on the vital statistics of the population of the United States.

Examination Components: Data are comprised of registration of vital events – births, deaths, marriages, divorces, and fetal deaths. 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 five territories (Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands).

Table 85. National Vital Statistics System (NVSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All births (about 4 million, annually); all deaths (about 2.8 million, annually); reported fetal deaths of 20+ weeks gestation; counts of marriages and divorces (total counts only)	Information available	White; Black; AI/AN; Asian; Hispanic; NHOPI	Birth – Source of payment for delivery; receipt of Women, Infants and Children's (WIC) program food for the pregnancy. Births and deaths – educational attainment	50 States, 2 cities (Washington, DC, and New York City), and five territories (Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands)	Ranging from 1968-present, depending on the file	Available	Annual

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

Brief Description: The State and Local Area Integrated Telephone Survey drew 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 non-parental care and children with ADHD or Tourette Syndrome). Survey modules included National Survey of Adoptive Parents 2007; National Survey of Adoptive Parents of Children with Special Health Care Needs 2008; National Survey of Children in Non-parental 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. Final data collection occurred in 2014.

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

Table 86. State and Local Area Integrated Telephone Survey

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Module-specific: all children; children with special healthcare needs; adopted children; children in non-parental 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; healthcare utilization; functioning; unmet needs; medical home	Module-specific: for National Survey of Children with Special Health Care 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: http://www.cdc.gov/nchs/slaits/slaits_products.htm

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

Data Source: Centers for Medicare and Medicaid Services (CMS) Research Data Assistance Center (ResDAC) (http://www.resdac.org)

Brief Description: The Centers for Medicare and Medicaid Services (CMS) 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 https://www.resdac.org/file/41.

Table 87. Centers for Medicare and Medicaid Services (CMS) Research Data Assistance Center (ResDAC)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Medicare and Medicaid populations	Older adults ≥ 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	Public Use Files, Virtual Research Data Center, Limited Datasets, Research Identifiable Files	Information on Medicare and Medicaid milestones available at https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf

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: CPM was developed by CMS.

Table 88. Medicare – Clinical Performance Measures Project

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available	Summary reports available at: http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html

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 healthcare.

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.

Table 89. Medicare – Hospital Compare

Target Population	Age	Race & Ethnicity	Socioeconomic 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 U.S. 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	Available	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: Centers for Medicare and Medicaid Services (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: The Centers for Medicare and Medicaid Services (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 healthcare 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: CPM developed by CMS.

Table 90. Centers for Medicare and Medicaid Services (CMS) Data Navigator, CMS Research, Statistics, Data & Systems

Target Population	Age	Race & Ethnicity	Socioeconomic 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 healthcare topics or settings-of-care	National, State	N/A	Available	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

Data Source: Mapping Medicare Disparities (MMD) Tool (https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html)

Brief Description: The MMD Tool is used to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. The MMD Tool is comprised of two views. The Population View provides a user-friendly way to explore and better understand disparities in chronic diseases, and allows users to: 1) visualize health outcome measures at a national, state, or county level; 2) explore health outcome measures by age, race and ethnicity, sex; 3) compare differences between two geographic locations (e.g., benchmark against the national average); and 4) compare differences between two racial and ethnic groups within the same geographic area. The Hospital View provides a user-friendly way to compare hospitals on quality of care (e.g., readmissions and unplanned hospital visits, safety and patient experience) and cost of care (e.g., Medicare spending). Users can visually analyze a hospital's metrics and performance scores and compare with other hospitals based on: geography (e.g., county, state, and national), hospital type (e.g., acute care and critical access), hospital ownership (e.g., government, physician, proprietary, tribal, and voluntary), and/or hospital size (i.e., number of beds). Information from both views may be used to inform policy decisions and to target populations and geographies for potential interventions.

Examination Components: The MMD Tool is used to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. CMS compiles data from the Chronic Conditions Warehouse for fee-for-services Medicare beneficiaries and hospital compare data.

Table 91. Mapping Medicare Disparities (MMD) Tool

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, hospitals, researchers, public, clinicians	All ages	All races/ethnicities	Medicare population by age, race, gender, coverage type, Medicare status, Fee-for-Service status	National, state, county	2012-2017	Available	N/A

Data Source: Minimum Data Set (MDS) (https://www.resdac.org/cms-data/files/mds-3.0)

Brief Description: MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidelines and time frames. In most cases, participants in the assessment process are licensed healthcare professionals employed by the nursing home.

Examination Components: MDS information is transmitted electronically by nursing homes to the national MDS database at CMS. MDS data can also be linked with Medicare claims data, for example data on prescription drug utilization (Part D), outpatient care (Part B), and inpatient care (Part A), to construct comprehensive histories of patient health status and healthcare utilization across sites of care.

Table 92. Minimum Data Set (MDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, states, government, researchers, public, clinicians	All ages	All races/ethnicities	All residents in Medicare and Medicaid certified nursing homes	National, state, county	2010-present	Available	Available at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/minimum-data-set-3-0-public-reports/index.html

Data Source: Outcome and Assessment Information Set (OASIS) (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html)

Brief Description: OASIS is the instrument/data collection tool used to collect and report performance data by home health agencies. Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid except for patients receiving pre- or postnatal services only. OASIS data are used for multiple purposes including calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts.

Examination Components: CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website “Home Health Compare.” These publicly reported measures include outcome measures which indicate how well home health agencies assist their patients in regaining or maintaining their ability to function and process measures which evaluate the rate of home health agency use of specific evidence-based processes of care.

Table 93. Outcome and Assessment Information Set (OASIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, states, government, researchers, public, clinicians	All ages	All races/ethnicities	Performance data by home health agencies	National	Unknown	Available	N/A

Data Source: Medicare Current Beneficiary Survey (MCBS) Public Use File (https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MCBS-Public-Use-File/index.html)

Brief Description: MCBS is a continuous, in-person, longitudinal survey of a representative national sample of the Medicare population, covering the population of beneficiaries in the U.S., District of Columbia, and Puerto Rico. It has been carried out continuously for more than 25 years, encompassing more than one million total interviews. The central goals of the MCBS are to determine expenditures and sources of payment for all services used by Medicare beneficiaries, including co-payments, deductibles, and non-covered services; to ascertain all types of health insurance coverage and relate coverage to sources of payment; and to trace outcomes over time, such as changes in health status and spending down to Medicaid eligibility and the impacts of Medicare program changes on satisfaction with care and usual source of care.

Examination Components: The MCBS is designed to aid CMS in administering, monitoring, and evaluating Medicare programs, is the leading source of information on Medicare and its impact on beneficiaries, provides important information on Medicare beneficiaries that is NOT available in CMS administrative data and plays an essential role in monitoring and examining healthcare access, utilization, and care transition and coordination.

Table 94. Medicare Current Beneficiary Survey (MCBS) Public Use File

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, states, government, researchers, public, clinicians	All ages	All races/ethnicities	Medicare beneficiaries	National	25 Years	Available	N/A

Data Source: Transformed Medicaid Statistical Information System (T-MSIS) (https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html)

Brief Description: The Transformed Medicaid Statistical information System (T-MSIS) is used to collect utilization and claims data as well as other key Medicaid and Children's Health Insurance Program information, to keep pace with the data needed to improve beneficiary quality of care, assess beneficiary to care and enrollment, improve program integrity, and support our states, the private market, and stakeholders with key information.

Examination Components: T-MSIS is a critical data and systems component of the CMS Medicaid and Children's Health Insurance Program Business Information Solution (MACBIS).

Table 95. Transformed Medicaid Statistical Information System (T-MSIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, states, government, researchers, public	All ages	All races/ethnicities	Medicaid population by age, race, gender, coverage type, Medicare & Medicaid status, beneficiaries' eligibility, enrollment	National, State, County	2012-2017	Available but may be restricted to certain data access until data are made publicly available	N/A

Data Source: Public Use File (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html)

Brief Description: The Geographic Variation Public Use File includes demographic, spending, utilization, and quality indicators at the state level (including the District of Columbia, Puerto Rico, and the Virgin Islands), hospital referral region (HRR) level, and county level, enabling researchers and policymakers to evaluate geographic variation in the utilization and quality of healthcare services for the Medicare fee-for-service population

Examination Components: The Geographic Variation Public Use File has 12 separate files – two files with state and county-level data, four files with only state-level data, and six files with HRR-level data. The files are presented in two different formats. The “Table” files present indicators for all states, counties, or HRRs, and can easily be exported from Excel to another data analysis program for additional analysis, while the corresponding “Report” files allow users to compare a specific state, county, or HRR to national Medicare benchmarks. The state- and HRR-level data include age breakouts (under 65, and 65 or older). Each file has a brief Methods section outlining the sample population and methodology that we used to calculate these indicators and a Documentation section which explains the individual indicators in more detail.

Table 96. Public Use File

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Policy makers, states, government, researchers, public	All ages	All races/ethnicities	Medicare fee-for-service (FFS)	National, State, County	2007-2017	Available	N/A

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. Food and Drug Administration

Data Source: FDA Adverse Event Reporting System (FAERS) (https://open.fda.gov/data/faers/)

Brief Description: FAERS is a database that contains information on adverse event and medication error reports submitted to FDA. The database is designed to support the FDA's post-marketing safety surveillance program for drug and therapeutic biologic products. The informatic structure of the FAERS database adheres to the international safety reporting guidelines issued by the International Conference on Harmonization (ICH E2B). Adverse events and medication errors are coded to terms in the Medical Dictionary for Regulatory Activities (MedDRA®) terminology.

Examination Components: FAERS is a useful tool for FDA for activities, such as looking for new safety concerns that might be related to a marketed product, evaluating a manufacturer's compliance to reporting regulations and responding to outside requests for information. The reports in FAERS are evaluated by clinical reviewers in the Center for Drug Evaluation and Research (CDER) and the Center for Biologics Evaluation and Research (CBER) to monitor the safety of products after they are approved by FDA. If a potential safety concern is identified in FAERS, further evaluation is performed. Further evaluation might include conducting studies using other large databases, such as those available in the Sentinel System. Based on an evaluation of the potential safety concern, FDA may take regulatory action(s) to improve product safety and protect the public health, such as updating a product’s labeling information, restricting the use of the drug, communicating new safety information to the public, or, in rare cases, removing a product from the market.

Table 97. FDA Adverse Event Reporting System (FAERS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All individuals	Information available by age and sex	Varies by report	N/A	N/A	1968 – Present	Quarterly data files and individual case reports available upon submission of FOIA request	FAERS Public Dashboard for querying of FAERS data (https://www.fda.gov/drugs/fda-adverse-event-reporting-system-faers/fda-adverse-event-reporting-system-faers-public-dashboard)

Data Source: Health and Diet Survey – HDS (https://www.fda.gov/media/96883/download)

Brief Description: Periodic telephone surveys conducted to monitor public awareness, knowledge, attitudes, and reported behavior related to food and nutrition. This intermittent data collection is active and will be merged into the "Food Safety and Nutrition Survey" beginning 2019."

Examination Components: National probability samples of persons 18 and older in households with telephones (and, in 2014, persons 18 and older with cell phones) in the continental United States are interviewed. The samples are selected using random digit dialing. Sample sizes varied over the years. Data collection include: Socioeconomic characteristics; knowledge, attitudes, and behavior related to foods, nutrition, diet, and food labeling.

Table 98. Health and Diet Survey – HDS

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals age 18 and over	18 and over	All races/ethnicities	Race/ethnicity; education; income; year of birth; gender; self-reported weight and height; self-reported chronic illnesses; number of adults living in the household	N/A	1982, 1984, 1986, 1988, 1994, 1995, 2002, 2004, 2008, 2014	Summary report and data available	Available at https://www.fda.gov/food/science-research-food/cfsan-consumer-behavior-research

Data Source: Drug Trials Snapshots (https://www.fda.gov/Drugs/InformationOnDrugs/ucm412998.htm)

Brief Description: Drug Trials Snapshots (DTS) provide consumers with information about who participated in clinical trials that supported the FDA approval of new drugs. DTS is part of an overall FDA effort to make trial demographic data more available and transparent as outlined in the FDA Action Plan to Enhance the Collection and Availability of Subgroup Data (2014).

Examination Components: The information provided in DTS highlights overall and subgroup demographic data and whether there were any differences in the benefits and side effects among sex, race and age groups.

Table 99. Drug Trials Snapshots

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Global, all ages	Information available by age and sex	American Indian/Alaskan Native; Asian; Native Hawaiian or Pacific Islander; Black; White; Other; Hispanic; Not of Hispanic Origin	N/A	Worldwide	Data starts with drugs/biologics approved by FDA beginning May 2014	New data is released per drug/biologic within 30 days of the medical product approval. Individual drug/biologic and summary data is freely available on the website. https://www.fda.gov/drugs/drug-approvals-and-databases/drug-trials-snapshots	Annual demographic summaries for approved drugs/biologics available on the web site since 2016.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Data Source: HIV/AIDS Bureau Ryan White HIV/AIDS Program AIDS Education and Training Centers (http://hab.hrsa.gov/abouthab/partfeducation.html)

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

National and regional AETCs include local performance sites, telehealth, and graduate health profession programs to 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 healthcare 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.

Table 100. HIV/AIDS Bureau Ryan White HIV/AIDS Program AIDS Education and Training Centers

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
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 healthcare 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. Resources are available at https://www.aidsetc.org/	N/A	N/A	N/A	Regional	Annually 2008-present	Available	Annual Reports are available at: https://hab.hrsa.gov/data/data-reports

Data Source: Area Resource File (https://data.hrsa.gov/topics/health-workforce/ahrf)

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 healthcare 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 healthcare delivery system because of its county-specific health resource information system.

Table 101. Area Resource File

Target Population	Age	Race & Ethnicity	Socioeconomic 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 (HAB) Ryan White HIV/AIDS Program Services Report (RWHAP) (http://hab.hrsa.gov/)

Brief Description: The RWHAP Services Report is an annual client-level data report that provides data on the characteristics of the HAB RWHAP recipients, their providers and the clients served.

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 RWHAP contract; and 3) the Client Report: contains client-level data for each client who received a RWHAP-funded service during the reporting period.

Table 102. HIV/AIDS Bureau Ryan White HIV/AIDS Program Services Report (RWHAP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with or affected by HIV who access RWHAP Services	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)	American Indian/ Alaskan Native; Asian; Black/African American; Hispanic/Latino; Native Hawaiian/Pacific Islander; White; Multiple races	Federal Poverty Level, Housing Status and Healthcare Coverage	Address of service provider where the individual received care	Annual; 2010-present	Aggregate data are available in the published Annual Client-Level Data report	Data are reported annually in the first quarter of the fiscal year following the end of the reporting year. The Ryan White Services Report submission deadline is March 31 every year. Aggregate reports and publications are available at: https://hab.hrsa.gov/data/data-reports

Data Source: National Survey of Children's Health (http://www.cdc.gov/nchs/slaits/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).

Table 103. National Survey of Children's Health

Target Population	Age	Race & Ethnicity	Socioeconomic 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; SNAP participation; WIC participation	State	January 2003 to July of 2004; April 2007 to July 2008; February 2011 through June 2012	Available	Periodically, available at: http://www.cdc.gov/nchs/slaits/nsch.htm

Data Source: National Survey of Children with Special Healthcare Needs (NS-CSHCN) (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 healthcare 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 are to assess the prevalence and impact of special healthcare 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.

Table 104. National Survey of Children with Special Healthcare Needs (NS-CSHCN)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
CSHCN 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	Available at: http://www.cdc.gov/nchs/slaits/cshcn.htm	Available at: http://www.cdc.gov/nchs/slaits/cshcn.htm The NS-CSHCN Chartbook 2009-2010 is available at http://mchb.hrsa.gov/cshcn0910/

Data Source: National Survey of Early Childhood Health (NSECH) (http://www.cdc.gov/nchs/slaits/nsech.htm)

Brief Description: The National Survey of Early Childhood Health (NSECH) was conducted with parents and guardians most responsible for the healthcare 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 MCHB 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.

Table 105. National Survey of Early Childhood Health (NSECH)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available at https://www.cdc.gov/nchs/slaits/nsech.htm	List of publications and resources available at https://www.cdc.gov/nchs/slaits/slaits_products.htm

Data Source: HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP), Dental Programs (http://hab.hrsa.gov/abouthab/partfdental.html)

Brief Description: Part F Dental Programs of the RWHAP: The Dental Services Report includes information on patient demographics, distribution of dental procedures, HIV-related collaboration activities and use of reimbursement award. 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 healthcare to people with HIV. The second program, Community-Based Dental Partnership Program (CBDPP), first funded in 2002, increases access to oral healthcare services for people with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings. CBDPP works through multi-partner collaborations between dental education and dental hygiene education programs and community-based dentists and dental clinics.

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; and
- Staffing and training.

Table 106. HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP), Dental Programs

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with HIV who access RWHAP services	Infants/toddles, children (12 and younger); youth, young adults (13 years to 24 years); adults (25 years to 64 years); and older adults (65 years and older)	American Indian/Alaskan Native; Asian; Black/African American; Hispanic/Latino; Native Hawaiian/ Pacific Islander; White; Multiple races	Federal Poverty Level, Housing Status and Healthcare Coverage	Address of service provider where the individual received care	Annual, 2002-present	Available	The Dental Services report submission deadline is July of every year. The data are available at: https://hab.hrsa.gov/stateprofiles2015/#/

Data Source: Title V Information System (TVIS) (https://grants6.tvisdata.hrsa.gov/Home) 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 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 healthcare 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://grants6.tvisdata.hrsa.gov/Home.

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 CSHCN) by assessing needs, setting priorities and providing programs and services.

Table 107. Title V Information System (TVIS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 https://grants6.tvisdata.hrsa.gov/	National, State	Ongoing	Available	Available for every year since 2009 at https://grants6.tvisdata.hrsa.gov/Home

Data Source: Title V Maternal and Child Health (MCH) Services Block Grant Accountability Program (https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program)

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 MCH 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 CSHCN; 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.

Table 108. Title V Maternal and Child Health (MCH) Services Block Grant Accountability Program

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Entire MCH population	Entire MCH population	Black or African American, White, Hispanic or Latino (of any race), Native American, Asian or Pacific Islander	N/A	National/State	Annual 2007 – present	Available at https://mchb.hrsa.gov/; (General Info) https://aspe.hhs.gov/health-resources-and-services-administration#BGA	National Data Reports range annually from 2008-2011, and 2007-2011. State Data Reports range annually from 1998-2011

Data Source: Uniform Data System (UDS) (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, healthcare 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 healthcare safety net for primary care.

Table 109. Uniform Data System (UDS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://datawarehouse.hrsa.gov/data/dataDownload.aspx	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 (UNOS) (https://optn.transplant.hrsa.gov/data/about-data/data-collection/)

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.

Table 110. United Network of Organ Sharing (UNOS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All national donors/ recipients	All	All races/ ethnicities	N/A	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 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.	Available by request at: https://unos.org/data/data-collection/	Program-Specific Report: Cohorts in the January 2013 reports span from 2006-2012; Scientific Registry of Transplant Recipients works jointly with OPTN to develop an Annual Data Report: (annually) 2003-2010; National Data: Includes the latest data about the status of U.S. organ donation and transplantation on a national level; Regional Data: Allows viewing the latest data about the status of U.S. organ donation and transplantation by UNOS region of center; State Data: Allows viewing the latest data about the status of U.S. organ donation and transplantation by state of center;

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
					UNet is being used by all 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.		Center Data: Includes current and historical information accumulated about individual transplant centers; Build Advanced Report: Allows viewing the latest data about the status of U.S. organ donation and transplantation. Can choose from several criteria to create a custom report; Annual Report Data: 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.

Data Source: Sickle Cell Disease Treatment Demonstration Program (SCDTDP) (https://mchb.hrsa.gov/fundingopportunities/?id=c6084989-3725-4b51-b309-206698402829)

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.

Table 111. Sickle Cell Disease Treatment Demonstration Program (SCDTDP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals with sickle cell disease	All ages	All, with predominance of African Americans/Blacks	Sociodemographic characteristics	N/A	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	Available	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 begins with a Quality Improvement workshop in the spring of 2011. Need to register in order to access data.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Data Source: American Indian and Alaska Native (AI/AN) Natality Database (https://www.ihs.gov/dps/)

Brief Description: The purpose of the American Indian and Alaska Native (AI/AN) Natality Database is to provide a data source for the analysis of American Indian and Alaska Native (AI/AN) births.[8]

Examination Components: The database includes all birth records for AIs/ANs (i.e., where either the mother or father or both are recorded as AI/AN on the birth certificate) residing in the United States. These are birth records (one record per birth) submitted by the States to the National Center for Health Statistics (NCHS).

Table 112. American Indian and Alaska Native (AI/AN) Natality Database

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native	Age of mother and father	American Indian and Alaska Native records only	N/A	IHS area and IHS service unit geographic codes; State and county of residence	Data are available for years 1972 to the present	Public use file available	Available at https://www.ihs.gov/dps/publications/

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[8] Includes data on mother and child's health. Data variables include the same as those on the national natality files available from the NCHS. Files are available within 3 to 4 months after receipt from NCHS. This periodic (annual) data collection is active. Data are obtained annually from NCHS.

Data Source: American Indian and Alaska Linked Birth/Infant Death Record Database (AIAN-LBID) (https://aspe.hhs.gov/indian-health-service)

Brief Description: The purpose of the American Indian and Alaska Linked Birth/Infant Death Record Database (AIA-LBID) is to provide a data source for the analysis of American Indian and Alaska Native (AI/AN) infant deaths.9

Examination Components: The database includes all death records matched by NCHS with birth records in which the subject individual was classified as an AI/AN (on either the birth record or the matched death record) for persons residing within the United States. Through performing a match between birth and infant death records, a more complete count of AI/AN infant deaths can be obtained (since it is believed that race is more accurately reported on State birth certificate records then on State death certificate records for infant deaths).

Table 113. American Indian and Alaska Linked Birth/Infant Death Record Database (AIAN-LBID)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native	Ages and gender of mother and father; age of infant at time of death	American Indian and Alaska Native records only	N/A	IHS area and IHS service unit geographic codes; State and county of residence.	Data are available for years 1983 to 1991 and 1995 and 1996. Data will not be available for data years 1992 to 1994, since NCHS will not prepare linked birth/infant death matched record files for these 3 data years	Data is available through computer generated tabulations and specially produced computer files. Requests for access to the data are handled on a request-by-request basis in accordance with appropriate confidentiality provisions. To access these files a confidentiality agreement must be completed by the requestor and submitted to NCHS, Division of Vital Statistics. Once approval to access these files is received by IHS from NCHS, access by the IHS will be granted	Available at https://www.ihs.gov/dps/publications/

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[9] Data variables include the same as those on the national linked birth/infant death matched record files available from NCHS. Files are available within 3 to4 months after receipt from NCHS. Data are obtained annually from NCHS.

Data Source: American Indian and Alaska Native Mortality Database (AIAN-MORT) (https://www.ihs.gov/dps/)

Brief Description: The purpose of the American Indian and Alaska Native Mortality Database (AIAN-MORT) is to provide a data source for the analysis of American Indian and Alaska Native (AI/AN) deaths. The database includes all death records for AI/AN (as coded on the death certificate) residing in the United States.

Examination Components: These are death records (one record per decedent) submitted by the States to NCHS. The Indian Health Service (IHS) obtains the files from NCHS and adds IHS administrative geographic codes to each record (IHS area and IHS service unit geographic codes). IHS determined there is misreporting of AI/AN race. Adjustments for misreporting were calculated based on a study utilizing the NDI maintained by NCHS. The adjustments were applied to the results obtained from using the unadjusted death file. Both unadjusted and adjusted data are available on the database.

Table 114. American Indian and Alaska Native Mortality Database (AIAN-MORT)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	Age and sex	American Indian and Alaska Native records only	N/A	IHS area and IHS service unit geographic codes; mortality data available is by State and county of residence	Data are available for years 1972 to 1999	Data are available through computer generated tabulations and specifically produced computer files. Requests for access to the database are handled on a request-by-request basis in accordance with appropriate confidentiality provisions set by NCHS. These files may be accessed following the completion of the confidentiality agreement by the requestor to NCHS. Once approval is received by IHS from NCHS access to the mortality database is granted	Available at https://www.ihs.gov/dps/publications/

Data Source: Indian Health Service Ambulatory Patient Care System (IHS-APCS) (https://www.ihs.gov/crownpoint/departments/ambulatorycare/)

Brief Description: The purpose of the Indian Health Services Ambulatory Patient Care System (IHS-APCS) is to collect diagnostic data on American Indians and Alaska Natives (AI/AN) receiving ambulatory medical care provided/funded by IHS.

Examination Components: All AI/AN who make an ambulatory visit to IHS and tribal direct and contract facilities have medical abstract records completed regarding their visit. Individual records are maintained for each visit with demographic and diagnostic information.

Table 115. Indian Health Service Ambulatory Patient Care System (IHS-APCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	N/A	American Indian and Alaska Native records only	N/A	N/A	Patient records are available for FY 1974 to the present	Requests for access to the data are handled on a request-by-request basis in accordance with appropriate confidentiality provisions. The requestor is required to sign an agreement regarding the use of the data and publication of results	Available at https://www.ihs.gov/dps/index.cfm/publications/trends2014/ https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2017_UIHP_UDS_Summary_Report_Final.pdf

Data Source: Indian Health Service Dental Services Reporting System (IHS-DSRS) (https://www.ihs.gov/phoenix/programsservices/dental/)

Brief Description: The purpose of the Indian Health Service Dental Services Reporting System (IHS-DSRS) is to collect dental services information on American Indians and Alaska Natives (AI/AN) receiving dental care provided/funded by IHS.[10]

Examination Components: Patient records are available for the latest five years. The data are analyzed by local service area and by age group starting at 0-4 years and going to 75+ years. The annual data analysis is available within three months of the close of the fiscal year. The data can be analyzed to the community of residence or facility level and by any age group.

Table 116. Indian Health Service Dental Services Reporting System (IHS-DSRS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	0-75 +	American Indian and Alaska Native records only	N/A	N/A	Data are available for FY 1971 to the present	Requests for access to the data are handled on a request-by-request basis in accordance with appropriate confidentiality provisions. The requestor is required to sign an agreement regarding the use of the data and publication of results	Available at https://www.ihs.gov/dps/index.cfm/publications/trends2014/ https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2017_UIHP_UDS_Summary_Report_Final.pdf For additional reports https://www.ihs.gov/dps/publications/

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[10] The data can be analyzed to the community of residence or facility level and by any age group.

Data Source: Indian Health Service Inpatient Care System (IHS-ICS) (https://www.ihs.gov/winnebago/services/inpatientclinic/)

Brief Description: The purpose of the Indian Health Service Inpatient Care System (IHS-ICS) is to collect diagnostic data on American Indians and Alaska Natives (AI/AN) receiving inpatient care provided/funded by IHS.

Examination Components: All AI/AN discharged from IHS and tribal direct and contract facilities have medical abstract records completed during their stay. Individual records are maintained for each discharge with demographic and diagnostic information.

Table 117. Indian Health Service Inpatient Care System (IHS-ICS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	N/A	American Indian and Alaska Native records only	N/A	N/A	Patient records are available for FY 1980 to the present	Requests for access to the data are handled on a request-by-request basis in accordance with appropriate confidentiality provisions. The requestor is required to sign an agreement regarding the use of the data and publication of results.	Available at https://www.ihs.gov/dps/publications/trends2014/ https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2017_UIHP_UDS_Summary_Report_Final.pdf For additional reports https://www.ihs.gov/dps/publications/

Data Source: Indian Health Service Patient Registration System (IHS-PTREG) (https://www.ihs.gov/ihm/pc/part-2/p2c6/)

Brief Description: The purpose of the Indian Health Service Patient Registration System (IHS-PTREG) is to collect demographic data on American Indians and Alaska Natives (AIs/ANs) receiving healthcare provided/funded by IHS. This is an active continuous data collection system. It is used for program planning and management.[11]

Examination Components: All AIs/ANs who access the IHS system are registered at the facility when they present themselves for service. A patient's record is updated when he/she reports changes, and patient records are periodically purged because of death or long periods of inactivity. Individual records are maintained for each patient with demographic and third-party eligibility information in an IHS central computer database.

Table 118. Indian Health Service Patient Registration System (IHS-PTREG)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	N/A	American Indian and Alaska Native only	N/A	N/A	Database contains only the latest data for each registrant and only current registrants	Requests for access to the data are handled on a request-by-request basis in accordance with appropriate confidentiality provisions. The requestor is required to sign an agreement regarding the use of the data and publication of results.	Available at https://www.ihs.gov/dps/publications/trends2014/ https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2017_UIHP_UDS_Summary_Report_Final.pdf For additional reports https://www.ihs.gov/dps/publications/

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[11] The data can be analyzed to the community of residence or facility level and by any age group. The data file for a fiscal year is available within three months of the close of the fiscal year.

Data Source: Indian Health Service Population Estimates and Projections (IHS-PEP) (https://www.ihs.gov/dps/aboutus/)

Brief Description: The purpose of the Indian Health Service Population Estimates and Projections (IHS-PEP) is to estimate and project counts of the American Indian and Alaska Native (AI/AN) population eligible for IHS services.12

Examination Components: Census enumeration counts for AI/AN by county are adjusted by AI/AN births and deaths to calculate (10-year linear regression) the natural change in projecting AI/AN counts beyond the last census (1990) through 2015.

Table 119. Indian Health Service Population Estimates and Projections (IHS-PEP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian and Alaska Native records only	Information on age/gender available	American Indian and Alaska Native records only	N/A	HIS Are, IHS service unit, State, and county geographic code	From 1970 to 1979, the counts are available only for the counties that make-up the IHS service area (i.e., "on or near" Federal Indian reservations). From 1980 on, counts are available for all U.S. counties.	Data are available through computer generated tabulations and specifically produced computer files. Requests for access to the database are handled on a request-by-request basis. Currently PDF files are available for the most recent projection tabulations.	Available at https://www.ihs.gov/dps/publications/trends2014/ For additional reports https://www.ihs.gov/dps/publications/

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[12] Estimates are available by age, gender, IHS Area, IHS service unit, State, and county geographic codes. Census enumeration counts are obtained from the Bureau of the Census. Birth and death records are obtained from the National Center for Health Statistics (NCHS).

Data Source: National Data Warehouse (DNW) (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 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.

Table 120. National Data Warehouse (DNW)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 ages	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: https://www.ihs.gov/dps/publications/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Data Source: Action to Control Cardiovascular Risk in Diabetes (ACCORD) (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.

Table 121. Action to Control Cardiovascular Risk in Diabetes (ACCORD)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	1999-2009	Available upon request through the National Heart, Lung and Blood Institute (NHLBI) data repository: (https://biolincc.nhlbi.nih.gov/studies/accord/)	List of study publications available at https://biolincc.nhlbi.nih.gov/studies/accord/

Data Source: Activity Counseling Trial (ACT) (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.

Table 122. Activity Counseling Trial (ACT)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 cardiovascular disease (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	N/A	1994-2002	Available upon request through the NHLBI Data Repository (https://biolincc.nhlbi.nih.gov/studies/act/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Activity+Counseling+Trial+%28ACT%29&acronym=ACT

Data Source: Alcohol Epidemiologic Data Directory (AEDS) (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.

Table 123. Alcohol Epidemiologic Data Directory (AEDS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Variable depending on dataset	Variable depending on dataset	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 http://pubs.niaaa.nih.gov/publications/2012DataDirectory/2012DataDirectory.htm#1

Data Source: Atherosclerosis Risk in Communities Study (ARIC) (https://biolincc.nhlbi.nih.gov/studies/aric/)

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 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.

Table 124. Atherosclerosis Risk in Communities Study (ARIC)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www2.cscc.unc.edu/aric/	• Annual Heart Disease and Stroke Statistical Update • Dietary Guidelines for Americans • HHS Physical Activity Guidelines for Americans • The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity • White House Report on Childhood Obesity • The Let’s Move Initiative • Resources on obesity research (prevention and treatment) in childhood: https://www.nhlbi.nih.gov/science/obesity-nutrition-and-physical-activity

Data Source: Cardiovascular Health Study (CHS) (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 CVD. The CHS 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 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 non-invasive 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 percent women 16 percent African American 31 percent had cardiovascular disease at entry).

Table 125. Cardiovascular Health Study (CHS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: Sacramento County, Sacramento, CA – University of California, Davis Washington County, Hagerstown, MD – Johns Hopkins University Forsyth County, Winston-Salem, NC – Wake Forest University School of Medicine Pittsburgh, PA – University of Pittsburgh	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: https://biolincc.nhlbi.nih.gov/studies/chs/) or through a collaboration with study investigators	October 2009: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/ (dup) Study results available in medical journal publications. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896383/

Data Source: Collaborative Psychiatric Epidemiology Surveys (CPES) (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 enough 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.

Examination Components: Interviews; response rate (percent); average interview length (minutes); average contacts per interview; National Comorbidity Survey Replication (NCS-R) Main respondent Second respondent; NSAL Adult respondent; NLAAS; Main respondent; Second respondent.

Table 126. National Comorbidity Survey Replication (NCS-R) (https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/190)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All adults, age 18+ residing in households in the coterminous United States; exclusions include institutionalized persons, those living on military bases and non-English speakers	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 same racial descent. Amount of time would like to spend w same racial/ethnic group. Importance for same racial/ethnic group to marry within group. Citizen of the United States. Citizenship in another country; Religious preferences. Frequency attending religious services. Importance of religious beliefs in daily life.	Census tract	2001-2003	Available publicly at: https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/20240/version/8 Restricted data sites available to apply for access: • NCSR Restricted Dataset (Excel 75K) • NSAL Restricted Dataset (Excel 52K) • NLAAS Restricted Dataset (Excel 66K) • CPES Restricted Crosswalk (Excel 109K)	Study publications are available at http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/20240#pubs

Table 127. National Survey of American Life (NSAL) (https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/190)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
African American, Afro-Caribbean and non-Hispanic White 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); Native American;	Amount of time would like to spend w same racial/ethnic group. Importance for same racial/ethnic group to marry within group. Citizen of the United States. Citizenship in another country; Religious preferences.	Census tract	2001-2003	Available publicly at: https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/190 Restricted data sites available to apply for access: • NCSR Restricted	Study publications are available at http://www.icpsr.umich.edu/icpsrweb/

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
those living on military bases and non-English speakers		Asian or Pacific Islander; Other	Frequency attending religious services. Importance of religious beliefs in daily life; (https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/190)			Dataset (Excel 75K) - NSAL Restricted Dataset (Excel 52K) - NLAAS Restricted Dataset (Excel 66K) - CPES Restricted Crosswalk (Excel 109K)	ICPSR/studies/20240#pubs

Table 128. National Latino and Asian American Study (NLAAS) (https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/00191)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
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	Adults 18 years and older	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Other	Education; questions about ability to pay bills or for food; employment. Feeling close in your ideas/feelings with same racial descent. Amount of time would like to spend with same racial/ethnic group. Importance for same racial/ethnic group to marry within group. Citizen of the United States. Citizenship in another country; Religious preferences. Frequency attending religious services. Importance of religious beliefs in daily life; (https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/00191)	Census tract	2001-2003	Available publicly at: https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/00191 Restricted data sites available to apply for access: - NCSR Restricted Dataset (Excel 75K) - NSAL Restricted Dataset (Excel 52K) - NLAAS Restricted Dataset (Excel 66K) - CPES Restricted Crosswalk (Excel 109K)	Study publications are available at http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/20240#pubs

Data Source: Coronary Artery Risk Development in Young Adults (CARDIA) (https://www.nhlbi.nih.gov/science/coronary-artery-risk-development-young-adults-study-cardia)

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 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). Most of the group has been examined at each of the follow-up examinations (90 percent, 86 percent, 81 percent, 79 percent, 74 percent and 72 percent, 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.

Table 129. Coronary Artery Risk Development in Young Adults (CARDIA)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www.cardia.dopm.uab.edu/ or through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/cardia/)	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 (ENRICHD) (https://biolincc.nhlbi.nih.gov/studies/enrichd/)

Brief Description: The objective of the Enhancing Recovery in CHD Patients (ENRICHD) 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.

Table 130. Enhancing Recovery in Coronary Heart Disease Patients (ENRICHD)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available through the NHLBI Data Repository	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Enhancing+Recovery+in+Coronary+Heart+Disease+Patients+%28ENRICHD%29&acronym=ENRICHD

Data Source: Epidemiologic Catchment Area Program (ECA) (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 (except for 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.

Table 131. Epidemiologic Catchment Area Program (ECA)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available through computer tapes (Accession Number available online: http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/06153/version/1#datasetsSection)	Study publications available at https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#pubs

Data Source: Established Populations for Epidemiologic Studies of the Elderly (EPESE) (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

Table 132. Established Populations for Epidemiologic Studies of the Elderly (EPESE)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	State	1981-1993	Available for download at: http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#datasetsSection	Study publications available at: http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/09915#pubs

Data Source: HDPulse – Data Portal (https://hdpulse.nimhd.nih.gov/)

Brief Description: HDPulse is an ecosystem of health disparities and minority health resources. The objective of the Data Portal is to characterize health disparities to motivate action to reduce health disparities. Interactive graphics and maps provide visual support for deciding where to focus public health disparities control efforts. The Data Portal brings together data that are collected from public health surveillance systems by using either their published reports or public use files.

Examination Components: N/A

Table 133. HDPulse – Data Portal

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Health disparity populations include racial/ethnic minorities, low socioeconomic status, rural, sexual and gender minorities, and/or others subject to discrimination who have poorer health outcomes often attributed to being socially disadvantaged, which results in being underserved in the full spectrum of healthcare	All ages. Male, Female	OMB Directive 15-definied racial and ethnic categories: American Indian or Alaska Native, Asian, Black or African American, Hispanic/Latino American, Native Hawaiian or Other Pacific Islanders	HDPulse has a wide range of socioeconomic variables including crowding (households with more than one person/room), education, income, health insurance, household mobility, non-English language speakers in the household, poverty, and unemployment	County	Data are the most recent that have completed the national data synthesis and quality assurance processes	Available for use from the NIMHD website at https://hdpulse.nimhd.nih.gov/index.html	Data are updated annually as new data become available. Details are at https://hdpulse.nimhd.nih.gov/about/

Data Source: Health Information National Trends Survey (HINTS) (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.

Table 134. Health Information National Trends Survey (HINTS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://hints.cancer.gov/terms.aspx (http://hints.cancer.gov/ >> Data/ Instruments >> Download Data)	HINTS Final Reports: http://hints.cancer.gov/instrument.aspx Briefs can be found here: http://hints.cancer.gov/briefs.aspx Peer-reviewed publications available at http://hints.cancer.gov/research.aspx

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

Brief Description: 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 healthcare, 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).

Table 135. Health and Retirement Study (HRS)

Population Target	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults (over the age of 50)[13]	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 healthcare expenditures [14]	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: http://hrsonline.isr.umich.edu/index.php?p=resdat	Link to publications and press releases can be found here: http://hrsonline.isr.umich.edu/index.php?p=pubs

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[13] 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

[14] 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 (HHP) (http://www.kuakini.org/programsservices/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 CVD, but whether this relation is independent of other CVD risk factors is uncertain. Most studies have focused on 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 HHP were examined and had fasting insulin levels measured. Hyperinsulinemia, defined as a fasting insulin > or =95th percentile among non-obese 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 non-diabetic subjects, associations were slightly weaker and in general non-significant. Non-diabetic 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/lifestyle; 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.

Table 136. Honolulu Heart Program (HHP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adult men All men in the study were Japanese Americans, American men of Japanese ancestry who were living on the island of Oahu in 1965. (http://www.bioportfolio.com/resources/trial/125261/Honolulu-Heart-Program.html)	Adult men (age at entry: 28-62 years)	Asian or Pacific Islander (Japanese-American)	Cultural assimilation of the family which includes the 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. There is also a series of 38 questions measuring the degree of agreement of the participant on statements about Japanese cultural values.	City: Honolulu, Hawaii	1965-1996	Data available upon request through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/hhp/)	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 HHP. Am J Epidemiol. 1994 Aug 1;140(3):206-16. (http://www.ncbi.nlm.nih.gov/pubmed/8030624?dopt=Abstract)

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.

Table 137. Jackson Heart Study

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available upon request, through the Jackson Heart Study or through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/jhs/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=The+Jackson+Heart+Study+%28JHS%29&acronym=JHS

Data Source: Lipid Research Clinics – Prevalence Study (LRCPS) (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.

Table 138. Lipid Research Clinics – Prevalence Study (LRCPS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available upon request through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/lrcps/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lipid+Research+Clinics+%28LRC%29+Prevalence+Study+%28PS%29&acronym=LRC-PS

Data Source: Lung Health Study (LHS) (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.

Table 139. Lung Health Study (LHS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	1984-2005	Available upon request through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/LHS/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Lung+Health+Study+%28LHS%29&acronym=LHS

Data Source: Monitoring the Future Survey (MTF) (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 8th- and 10th-grade students, 12th-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.

Table 140. Monitoring the Future Survey (MTF)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescent students	8th-, 10th-, and 12th-graders; college students; and young adults	Black; White; Hispanic[15]	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[16]	Public Use Files available here: https://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future	Regular press releases can be found here: http://monitoringthefuture.org/press.html

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[15] 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].

[16] 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 8th- and 10th-grade students began in 1991.

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

Brief Description: The Multi-Ethnic Study of Atherosclerosis (MESA) investigates the prevalence, correlates and progression of subclinical 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.

Table 141. Multi-Ethnic Study of Atherosclerosis (MESA)

Target Population	Age	Race & Ethnicity	Socioeconomic 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)	Available upon request, through the MESA Study at http://www.mesa-nhlbi.org/ or through the NHLBI data repository at (https://biolincc.nhlbi.nih.gov/studies/mesa/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multi-Ethnic+Study+of+Atherosclerosis+%28MESA%29&acronym=MESA

Data Source: Multiple Risk Factor Intervention Trial (MRFIT) (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.

Table 142. Multiple Risk Factor Intervention Trial (MRFIT)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	1972-1998	Available upon request through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/mrfit/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Multiple+Risk+Factor+Intervention+Trial+for+the+Prevention+of+Coronary+Heart+Disease+%28MRFIT%29&acronym=MRFIT

Data Source: National Archive of Computerized Data on Aging (NACDA) (https://www.icpsr.umich.edu/icpsrweb/NACDA/)

Brief Description: NACDA is funded by the National Institute on Aging, National Institutes of Health. NACDA acquires and preserves data relevant to gerontological research, processing as needed to promote effective research use, disseminates them to researchers for secondary analysis on major issues of scientific and policy relevance.17

Examination Components: Because of the variety of datasets available, multiple examination components are evaluated. Search mechanisms for these datasets offers a broad array of filters/subjects' terms, facilitating retrieval of specific information being sought.

Table 143. National Archive of Computerized Data on Aging (NACDA)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Older adults	N/A	N/A	N/A	N/A	N/A	Publicly available datasets and those with a more restrict access	A considerable amount of bibliography of data-related literature is provided. Search mechanisms include searching by author, journal title, study number

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[17] Information also provided on the activities of NIA-Funded Centers, including the Centers on Demography of Aging (13 P30 centers), at leading universities and policy organizations around the US. These centers aim to foster research in demography, economics and epidemiology of aging and to promote use of important datasets in the field. Information is also provided on the Resource Centers for Minority Aging Research (RCMAR) and their activities towards decreasing health disparities The RCMAR includes: 1) Center for Aging in Diverse Communities, University of California; 2) Center for Health Improvement of Minority Elders, University of California, los Angeles; 3) Comprehensive Center for Healthy Aging, University of Alabama; 4) Deep South Resource Center for Minority Aging Research, University of Alabama, Birmingham; 5) Latino Aging Research Resource Center, University of California, Davis; 6) Michigan Center for Urban African American Aging research, Wayne State University; 7) Minority Aging Health Economics Research center, University of Southern California; 8) Native Elder Research Center, University of Colorado, Denver.

Data Source: National Comorbidity Survey (NCS) (http://www.icpsr.umich.edu/icpsrweb/DSDR/studies/6693)

Brief Description: NCS was a collaborative epidemiologic investigation designed to study the prevalence and correlates of DSM III-R disorders and patterns and correlates of service utilization for these disorders. The NCS was the first survey to administer a structured psychiatric interview to a nationally representative sample.

Examination Components: Prevalence and correlates of DSM III-R disorders and patterns and correlates of service utilization for these disorders. Drugs covered by this survey include alcohol, tobacco, sedatives, stimulants, tranquilizers, analgesics, inhalants, marijuana/hashish, cocaine, hallucinogens, heroin, non-medical use of prescription drugs, and polysubstance use. Other items include demographic characteristics, personal and family history of substance use and abuse, substance abuse treatment, data on drug use including recency, frequency, and age at first use, problems resulting from the use of drugs, personal and family history of psychiatric problems, mental health treatment, symptoms of psychiatric disorders, mental health status, HIV risk behaviors, and physical health status.[18]

Table 144. National Comorbidity Survey (NCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
early 1990s with a household sample of over 8,000 respondents. Subsamples of the original respondents completed the NCS Part II survey and Tobacco Use Supplement. Diagnoses were based on a modified version of the Composite International Diagnostic Interview (the UM-CIDI), which was developed at the University of Michigan for the NCS	Information available by gender and age	Hispanic descent, white, Black or other	Information available	N/A	Decade of 1990	Available upon request, with special agreement with user. These instruments are posted for informational purposes only and should not be used by other investigators without proper training	N/A

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[18] These instruments are posted for informational purposes only and should not be used by other investigators without proper training. Training is no longer being provided for the Baseline NCS instrument or for the Baseline NCS Clinical Reappraisal Interview Schedule. Training for use of updated versions of the NCS-R interview schedules and the WMH PAPI interview schedule is available through the World Health Organization CIDI Training and Reference Center at the University of Michigan. Contact Beth Ellen Pennell, Director of the CIDI TRC, at bpennell@umich.edu or 734-222-8905. The Michigan CIDI TRC also offers training in an updated PAPI version of the NCS-R interview schedule. CAPI training includes a copy of the Blaise CAPI program, while PAPI training includes a copy of the Blaise Direct Data Entry program for keypunching the interview data. Both CAPI and PAPI training includes a copy of SAS programs to generate DSM-IV and ICD-10 diagnoses.

Data Source: National Comorbidity Survey Replication Study (NCS-R) (http://www.icpsr.umich.edu/icpsrweb/DSDR/studies/00189)

Brief Description: The NCS-Replication researchers studied a new nationally representative sample of the U.S. population, repeating many of the questions from the original NCS and expanding the original study's scope by incorporating updated disease assessment criteria based on the Fourth Edition of the DSM (DSM-IV). The goal was to uncover trends in mental health prevalence, impairment, and service use over the decade of the 1990s. In addition, data were collected in accordance with the World Health Organization's (WHO) World Mental Health Survey Initiative, which seeks to gather reliable, cross-national analyses of mental, substance use, and behavior disorders in 28 countries, representing all WHO regions; these efforts will help validate the estimates of mental health burden, identify barriers to service, and evaluate intervention targets on a worldwide scale.

Examination Components: The NCS-R repeats many of the questions from the NCS-1 and expands the questioning to include assessments based on the diagnostic criteria of the American Psychiatric Association as reported in the Diagnostic and Statistical Manual – IV (DSM-IV), 1994. The two major aims of the NCS-R were first, to investigate time trends and their correlates over the decade of the 1990s, and second, to expand the assessment in the baseline NCS-1 in order to address a number of important substantive and methodological issues that were raised by the NCS-1. The NCS-R is part of the CPES data collection (see ICPSR20240). Data and documentation for NCS-R can be accessed through the CPES Web site.

Table 145. National Comorbidity Survey Replication Study (NCS-R)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
9,282 adult interviews were completed	Information available by gender and age	N/A	Available	252 geographic areas or primary sampling units across the United States	2001-2003	These data are not available from Data Sharing for Demographic Research (DSDR). Users should consult the data owners directly (via CPES Web site) for details on obtaining these resources.; One or more files in this data collection have special restrictions; consult the restrictions note to learn more. You can apply online for access to the restricted-use data. A login is required to apply. Any public use data files in this collection are available for access by the general public. Access does not require affiliation with an Inter-university Consortium for Political and Social Research (ICPSR) member institution.	N/A

Data Source: National Cooperative Inner-City Asthma Study, Phase I (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 healthcare, 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

Table 146. National Cooperative Inner-City Asthma Study, Phase I

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www.cdc.gov/asthma/interventions/inner_city_asthma_researchbase.htm 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 (NCICAS), 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 is 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 healthcare 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.19

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 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.[20]

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[19] Szefler SJ, Mitchell H, Sorkness CA, Gergen PJ, O'Connor GT, Morgan WJ, Kattan M, Pongracic JA, Teach SJ, Bloomberg GR, Eggleston PA, Gruchalla RS, Kercsmar 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 randomized controlled trial. Lancet. 372(9643):1065-72 (2008).

[20] 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, Szefler SJ, Sorkness CA. Randomized trial of omalizumab (anti-IgE) for asthma in inner-city children. *N Engl J Med*. 364(11):1005-15 (2011).

Table 147. National Cooperative Inner-City Asthma Study (NCICAS), Phase II

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www.niaid.nih.gov/topics/asthma/research/Pages/innerCity.aspx#ncicas	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 Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (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.

Table 148. National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 [21]	County	First wave: 2001-2002 Second wave: 2004-2005 Third wave: 2011-2012	Available upon agreement of terms at http://www.niaaa.nih.gov/research/nesarc-iii/nesarc-iii-data-access	Summary of selected findings available at http://pubs.niaaa.nih.gov/publications/AA70/AA70.htm

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[21] Other variables: traditional households, military personnel living off base, boarding or rooming houses, college quarters.

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

Brief Description: The 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 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. Secondarily, 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.

Table 149. National Growth and Health Study (NGHS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 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 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: https://biolincc.nhlbi.nih.gov/studies/nghs/)	White House Task Force on Childhood Obesity Report to the President: https://letsmove.obamawhitehouse.archives.gov/white-house-task-force-childhood-obesity-report-president Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=NHLBI+Growth+and+Health+Study+%28NGHS%29&acronym=NGHS

Data Source: National Latino and Asian American Study (NLAAS) (http://www.healthequityresearch.org/)

Brief Description: The NLAAS provides national information on the similarities and differences in mental illness and service use of Latinos and Asian Americans, as compared to non-Latino Whites and African Americans.22

Examination Components: Mental illness and service use.

Table 150. National Latino and Asian American Study (NLAAS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
2554 Latinos (Puerto Ricans, Mexican Americans, Cubans and Other Latinos) and 2095 Asian American respondents (Chinese, Vietnamese, Filipinos, and Other Asians)	Information available by gender and age	Latinos and Asian Americans, as compared to non-Latino Whites and African Americans	N/A	N/A	N/A	N/A	N/A

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[22] Part of Collaborative Psychiatric Epidemiology Surveys (CPES) data collection - already on the compendium

Data Source: National Longitudinal Alcohol Epidemiologic Survey (NLAES) (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.

Table 151. National Longitudinal Alcohol Epidemiologic Survey (NLAES)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Public use dataset is available from Cornell University, Cornell Institute for Social and Economic Research Catalog files available at https://catalog.archives.gov/id/598151	Findings from the 1992 survey available at http://pubs.niaaa.nih.gov/publications/Nlaesdrm.pdf

Data Source: National Longitudinal Mortality Study (NLMS) (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 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, non-institutionalized 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.

Table 152. National Longitudinal Mortality Study (NLMS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www.census.gov/did/www/nlms/publications/public.html 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: http://www.census.gov/nlms/bibliography.html

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 to Adult 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.

Table 153. National Longitudinal Study of Adolescent to Adult Health (AddHealth)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adolescents (followed into young adulthood)[23]	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	Public Use Datasets can be found here: http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/21600. 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: http://www.cpc.unc.edu/projects/addhealth/data	Study publication are available at http://www.icpsr.umich.edu/icpsrweb/ICPSR/biblio/studies/21600/resources?collection=DATA&archive=ICPSR&sortBy=1

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[23] 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 (NLTCS) (https://www.nia.nih.gov/research/resource/national-long-term-care-survey-nltcs)

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 Apolipoprotein E (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 Angiotensin converting enzyme inhibitors (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 healthcare 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 healthcare 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.

Table 154. National Long-Term Care Survey (NLTCS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available upon registration at: http://www.icpsr.umich.edu/icpsrweb/NACDA/studies/9681?classification=CD-ROM.I.*&archive=NACDA#datasetsSection	Study publications are available at http://www.icpsr.umich.edu/icpsrweb/NACDA/biblio/studies/9681/resources?collection=DATA&archive=ICPSR&sortBy=1

Data Source: National Survey of Adolescent Males (NSAM) (https://sites.google.com/site/cahjhsph/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 like 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.

Table 155. National Survey of Adolescent Males (NSAM)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 (http://www.socio.com), or by calling 1-800-846-DISK	Study publications available at https://sites.google.com/site/cahjhsph/national-survey-of-adolescent-males

Data Source: National Survey of American Life (NSAL) (http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/190?archive=ICPSR&q=nsal)

Brief Description: The National Survey of American Life (NSAL) is a study designed to explore racial and ethnic differences in mental disorders, psychological distress, and informal and formal service use from within the context of a variety of presumed risk and protective factors in the African American and Afro-Caribbean populations of the United States as compared with White respondents living in the same communities. The NSAL is part of the CPES data collection.[24]

Examination Components: Main components include mental and psychological conditions, and informal and formal services utilization.

Table 156. National Survey of American Life (NSAL)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Populations with mental health issues	Information available by gender and age	African American and Afro-Caribbean populations of the United States	N/A	N/A	2001-2003	These data are not available from ICPSR. Users should consult the data owners directly (via Collaborative Psychiatric Epidemiology Surveys) for details on obtaining these resources	N/A

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[24] part of Collaborative Psychiatric Epidemiology Surveys (CPES) data collection - already on the compendium (see ICPSR20240). Data and documentation for NSAL can be accessed through the CPES Web site.

Data Source: National Survey of Health and Stress (NSHS) (https://www.rwjf.org/en/library/research/2014/07/the-burden-of-stress-in-america.html)

Brief Description: The National Survey of Health and Stress (NSHS) was a 1991 household survey of persons aged 15-54 which collected data on drug abuse and mental health. The study was designed to provide nationally representative estimates of psychiatric disorders (including substance abuse), as defined by DSM-III-R criteria. It included about 8,000 households and was conducted by the Institute for Social Research under a grant from the National Institute for Mental Health with additional support from NIDA.

Examination Components: Drug abuse and mental health in households.

Table 157. National Survey of Health and Stress (NSHS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
8,000 households, age 15-54	Information available by age and sex	N/A	N/A	N/A	1991	N/A	N/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.

Table 158. National Survey on Energy Balance-Related Care among Primary Care Physicians

Target Population	Age	Race & Ethnicity	Socioeconomic 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)	N/A	N/A	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 http://appliedresearch.cancer.gov/cgi-bin-pubsearch/pubsearch/index.pl?initiative=EBAL

Data Source: Puerto Rico Heart Health Program (PRHHP) (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 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.

Table 159. Puerto Rico Heart Health Program (PRHHP)

Target Population	Age	Race & Ethnicity	Socioeconomic 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 [25]	State	1965-1980	Data available upon request through the NHLBI Data Repository (BioLINCC: https://biolincc.nhlbi.nih.gov/studies/prhhp/)	Study publications available at https://biolincc.nhlbi.nih.gov/publications/?studies.raw=Puerto+Rico+Heart+Health+Program+%28PRHHP%29&acronym=PRHHP

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[25] 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 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.

Table 160. Registry and Surveillance of Hemoglobinopathies

Target Population	Age	Race & Ethnicity	Socioeconomic 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 disease, thalassemias and hemoglobin E disease	All ages	All, but primarily African Americans	N/A	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	N/A	Available at https://www.cdc.gov/ncbddd/hemoglobinopathies/rush.html or http://www.cdc.gov/ncbddd/hemoglobinopathies/documents/rush-strategies_508.pdf 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.

Table 161. State Cancer Profiles

Target Population	Age	Race & Ethnicity	Socioeconomic 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 http://statecancerprofiles.cancer.gov/about/ The site provides prepared reports, graphs, maps and interactive tools. Users can also prepare their own tailored reports, available at http://statecancerprofiles.cancer.gov/

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

Brief Description: The SEER of the 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.

Table 162. Surveillance, Epidemiology, and End Results (SEER) Program Registries

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All ages	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: (http://seer.cancer.gov/data/access.html) SEER research data files and software are available to download or via discs shipped directly.	Annual Report available at https://seer.cancer.gov/report_to_nation/ Updated annually and provided in print and electronic formats at http://seer.cancer.gov/report_to_nation/archive.html

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SEER Linked Databases

(https://seer.cancer.gov/data-software/linked_databases.html)

The National Cancer Institute (NCI) Surveillance, Epidemiology, and End Results (SEER) Program provides information on cancer statistics to reduce the cancer burden among the U.S. population. Below is information on relevant SEER data linkage initiatives.

SEER-Medicare Linked Database

https://healthcaredelivery.cancer.gov/seermedicare/

The SEER-Medicare data reflect the linkage of two large population-based sources of data that provide detailed information about Medicare beneficiaries with cancer, which can be used for an array of epidemiological and health services research. The data come from the Surveillance, Epidemiology and End Results (SEER) program of cancer registries that collect clinical, demographic and cause of death information for persons with cancer and the Medicare claims for covered healthcare services from the time of a person's Medicare eligibility until death.

The linkage of these two data sources results in a unique population-based source of information that can be used for an array of epidemiological and health services research. For example, investigators using this combined dataset have conducted studies on patterns of care for persons with cancer before a cancer diagnosis, over the period of initial diagnosis and treatment, and during long-term follow-up. Investigators have also examined the use of cancer tests and procedures and the costs of cancer treatment.

The linked SEER-Medicare data files are large and complex. Before beginning an analysis, researchers are advised to read all documentation to determine whether the data will support their proposed research question. In addition, the SEER-Medicare data have several qualities and anomalies. Researchers are strongly encouraged to understand the complexity of the data before undertaking any analyses or publishing findings. Please be aware that in compliance with CMS, NCI no longer release SEER-Medicare data outside the USA.

SEER-Medicare Health Outcomes Survey Linked Database

https://healthcaredelivery.cancer.gov/seer-mhos/

The SEER-MHOS database links two large population-based sources of data that provide detailed information about elderly persons with cancer. The data come from the SEER cancer registries that collect clinical, demographic and cause of death information for persons with cancer and the Medicare Health Outcomes Survey (MHOS) that provides information about the health-related quality of life (HRQOL) of Medicare Advantage Organization (MAO) enrollees.

The SEER-MHOS data resource is a resource designed to improve the researcher's understanding of the HRQOL of cancer patients and survivors enrolled in MAOs. The SEER-MHOS database is sponsored by the NCI and the Centers for Medicare & Medicaid Services (CMS).

The NCI and CMS partnership in this initiative is modeled on the SEER-Medicare linked database. For the SEER-MHOS data resource, CMS provides the MHOS data and NCI provides the SEER data. NCI manages the SEER-MHOS data resource, but both agencies work together to update and improve the database over time. Both agencies also collaborate in creating and carrying out the research plan that guides the initiative.

The linkage now includes MHOS 18 cohorts (1998-2017) as well as cancer data from SEER (1973-2015) for all matches included in the SEER-MHOS file. The SEER-MHOS database is now also linked to Medicare Part D enrollment and claims data may now be requested as part of a SEER-MHOS Data Use Agreement (DUA) application.

Because these files are large and complex, before beginning an analysis using SEER-MHOS data researchers are encouraged to read through the data tables and figures in the SEER-MHOS Data File section of the SEER-MHOS Web site, and the training module in the analytic support section, to gain a better understanding of the linked data. In addition, researchers are strongly encouraged to reach out for information and technical support at SEER-MHOS@hcqis.org to help understand the intricacies of the data before making requests and undertaking any analyses.

SEER-Consumer Assessment of Healthcare Providers and Systems (SEER-CAHPS) Linked Data Resource

https://healthcaredelivery.cancer.gov/seer-cahps/

The SEER-CAHPS data set is a resource for quality of cancer care research based on a linkage between the NCI's SEER cancer registry data and the Centers for Medicare & Medicaid Services' (CMS) Medicare CAHPS patient surveys. The SEER-CAHPS data set links three types of data: clinical/registry (SEER), survey (CAHPS), and administrative/billing (Medicare claims and enrollment files). The data are linked through the collaborative efforts of NCI, the SEER registries, and CMS.

The SEER Program works to provide information on cancer statistics to reduce the burden of cancer among the U.S. population. SEER collects data on cancer cases from various locations and sources throughout the U.S. Data collection began in 1973 with a limited number of registries and continues to expand to include even more areas and demographics today. Since 1997, CMS has sponsored annual administrations of the Medicare CAHPS surveys to assess the healthcare experiences of Medicare enrollees in Medicare Advantage (MA) and FFS. The CAHPS surveys are some of the most widely used instruments for measuring U.S. healthcare quality.

These data provide a rich opportunity for analyses of Medicare beneficiaries' experiences with their care at various stages of the cancer care continuum, including initial year after diagnosis, when patients are most likely to receive cancer treatments; post-treatment follow-up care; long-term cancer survivorship; and final end-of-life care. Analyses from these data have the potential to fill an important gap in existing knowledge by enabling comparisons of patients' care experiences between MA and FFS beneficiaries and between patients with and without cancer. For Medicare FFS beneficiaries, the SEER-CAHPS data set also allows for the evaluation of their healthcare utilization and costs of care through the linkage to Medicare claims.

Data Source: Treatment of Depression Collaborative Research Program (TDCRP) (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.

Table 163. Treatment of Depression Collaborative Research Program (TDCRP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Mental health outpatients	N/A	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 http://www.ncbi.nlm.nih.gov/pubmed/2684085

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 non-pharmacologic 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.

Table 164. Trials of Hypertension Prevention, Phases I and II

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	1986-1998	Available upon request through the NHLBI Data Repository: (https://biolincc.nhlbi.nih.gov/studies/tohp/)	List of publications available at https://www.clinicaltrials.gov/ct/show/NCT00000528?order=1

Data Source: U.S. Renal Data System (USRDS) (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 end-stage renal disease (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.

Table 165. U.S. Renal Data System (USRDS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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: http://www.usrds.org/render/xrender_home.asp)	1994-present	Online data, query system: (http://www.usrds.org/render/xrender_home.asp) and researcher's guide; database is available with approved research protocols: (http://www.usrds.org/request.aspx)	Annual data report (archived since 1994) available at: http://www.usrds.org/adr.aspx and quarterly updates: (http://www.usrds.org/qtr/default.aspx)

Data Source: Women's Health Initiative Observational Study (WHI-OS) (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.

Table 166. Women's Health Initiative Observational Study (WHI-OS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available upon request through the WHI Study or through the NHLBI Data Repository (https://biolincc.nhlbi.nih.gov/studies/whi-other/)	Summary of key findings and publications available at https://www.nhlbi.nih.gov/whi/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Data Source: Drug Abuse Warning Network (DAWN) (https://datafiles.samhsa.gov/study-series/drug-abuse-warning-network-dawn-nid13516 and https://www.samhsa.gov/data/data-we-collect/dawn-drug-abuse-warning-network)

Brief Description: DAWN is a nationally represented public health surveillance system that continuously monitors drug-related visits to hospital emergency departments (EDs). A DAWN case is any ED visit involving recent drug use that is implicated in the ED visit. DAWN captures both ED visits that are directly caused by drugs and those in which drugs are a contributing factor, but not the direct cause of the ED visit. Annually, DAWN produces estimates of drug-related visits to hospital EDs for the nation and for selected metropolitan areas.26

Examination Components: DAWN continued to produce estimates of drug abuse-related emergency department visits for the contiguous United States and 21 metropolitan areas through 2002. Because there were population shifts and changes in the hospital industry, DAWN implemented a sample redesign in 2003. Many other features of DAWN (e.g., redefining a DAWN visit to include all drug-related medical emergencies and not merely those involving misuse or abuse; the introduction of estimates that were representative of the Nation; changes in case-finding methodology etc.) were also introduced at that time. The medical examiner/coroner component of DAWN continued to collect data on drug-related deaths through 2010.

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[26] DAWN was established in 1972 by the Drug Enforcement Administration (DEA) to track emergency department (ED) visits caused by drug abuse in order to identify the drugs being abused, determine patterns in selected metropolitan areas and changing trends across the country, including the detection of new substances of abuse and new combinations. Initially focusing on metropolitan areas only, the system was later expanded to produce estimates for the U.S. and to capture deaths drug abuse-related deaths investigated by medical examiners/coroners in selected metropolitan areas. DAWN was transferred to the U.S. Department of Health and Human Services (DHHS) in 1980, where it was conducted by the National Institute on Drug Abuse (NIDA) within the National Institutes of Health (NIH). When NIDA assumed responsibility for DAWN, implementation of a sample of hospitals to produce representative estimates for the Nation and for selected metropolitan areas became a priority. In 1992, the Substance Abuse and Mental Health Services Administration (SAMHSA) took responsibility for DAWN and through 2011, the Center for Behavioral Health Statistics and Quality (CBHSQ, formerly the Office of Applied Studies) was responsible for DAWN operations and reporting.

Table 167. Drug Abuse Warning Network (DAWN)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
DAWN Emergency Department component target population consists of all non-federal, short-stay, general medical and surgical hospitals in the United States that have one or more EDs open 24 hours a day	All ages	All races/ethnicities	N/A	DAWN Emergency Department component includes estimates for metropolitan areas Boston, Chicago, Denver, Detroit, Miami-Dade Division, Miami-Fort Lauderdale Division, Minneapolis, New York City (5 Boroughs), Phoenix, San Francisco Division, and Seattle. DAWN medical examiner/coroner component covers metropolitan areas in 37 states, with complete coverage of 13 states	Emergency Department from 2004 to 2011 and Medical Examiners and Coroners from 2003 to 2010	The public use data files for Emergency Department are available for access by the general public	Emergency Department from 2004 to 2011 and Medical Examiners and Coroners from 2003 to 2010

Data Source: Drug and Alcohol Services Information System (DASIS) (https://wwwdasis.samhsa.gov/dasis2/index.htm)

Brief Description: DASIS results from the staged integration of three Substance Abuse and Mental Health Services Administration (SAMHSA) data systems: The National Facility Register (NFR), the Treatment Episode Data Set (TEDS) (previously, the Client Data System [CDS]), and the Uniform Facility Data Set (UFDS) (previously, the National Drug and Alcoholism Treatment Unit Survey [NDATUS]). The NFR is SAMHSA's master list of all organized substance abuse treatment and prevention programs. The TEDS comprises States' minimum data sets on admissions to publicly funded treatment facilities. The UFDS has been a periodic point-prevalence survey of all known public and private substance abuse treatment facilities. The DASIS will establish a statistical data set on treatment facilities and services in the United States. Three interrelated data sets (the NFR, the TEDS, and the UFDS) will be linkable, permitting integrated analysis. The DASIS will provide both national- and state-level data on the numbers and types of patients treated for substance abuse and the characteristics of facilities providing services. The DASIS will promote the implementation of common data standards to enhance the quality, uniformity, and availability of core data items and definitions within state alcohol and drug abuse programs. Files contain data on: Services Resources; Services Utilization; Services Expenditure and Financing; Socioeconomic; Age/Gender; Other Demographic/Sociocultural; Behavioral; and Other (characteristics of substance abuse treatment facilities, persons admitted for treatment). This data collection is active. (Data on client admissions are collected continuously, and census of facilities is conducted annually with some gaps.) START DATE: September 1974 (UFDS); 1990 (TEDS).27

Examination Components: DASIS is the primary source of national information on the services available for substance abuse treatment and the characteristics of individuals admitted to treatment. DASIS contains three data sets which are maintained with the cooperation and support of the States:

1. The Inventory of Behavioral Health Services (I-BHS), an electronic master list of all organized substance abuse treatment facilities known to the Substance Abuse and Mental Health Services Administration (SAMHSA),
2. The National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of the treatment providers on the I-BHS; and
3. The Treatment Episode Data Set (TEDS), a national database containing a minimum data set of information about individuals admitted to and discharged from treatment (primarily by providers receiving public funding).

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[27] more help: https://wwwdasis.samhsa.gov/dasis2/staff.htm

Table 168. Drug and Alcohol Services Information System (DASIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
See information above	All ages	All races/ethnicities	Files contain data on: Services Resources; Services Utilization; Services Expenditure and Financing; Socioeconomic; Age/Gender; Other Demographic/Sociocultural; Behavioral; and Other (characteristics of substance abuse treatment facilities, persons admitted for treatment)	State	N/A	N/A	This data collection is active. (Data on client admissions are collected continuously, and census of facilities is conducted annually with some gaps.) START DATE: September 1974 (UFDS); 1990 (TEDS)

Data Source: National Survey on Drug Use and Health (NSDUH) (https://nsduhweb.rti.org/respweb/homepage.cfm; http://pdas.samhsa.gov/#/)

Brief Description: NSDUH provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States.

NSDUH is directed by SAMHSA.

Examination Components: The annual survey of the U.S. population ages 12 years or older. The survey is a cross-sectional survey that collects several measures, including: use of illegal drugs, prescription drugs, alcohol, and tobacco; mental disorders, treatment, and co-occurring substance use and mental disorders Personal interviews with selected households.

Table 169. National Survey on Drug Use and Health (NSDUH)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
70,000 respondents	Information available	White; Black/African American; AI/AN; NHPI; Asian; Multiple races; Hispanic	Income, Employment, Housing, Education, health insurance	Based on a small area estimation (SAE) which includes county and subcounty level census data from each state	1971-present	Available	Annual

Data Source: National Mental Health Services Survey (N-MHSS) (https://www.samhsa.gov/data/data-we-collect/nmhss-national-mental-health-services-survey)

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.

Table 170. National Mental Health Services Survey (N-MHSS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	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	N/A	State	June 2010 through January 2011 with a reference date of April 30, 2010	Public Use Files available at: https://www.samhsa.gov/data/data-we-collect/nmhss-national-mental-health-services-survey	Available at: https://www.samhsa.gov/data/report/2019-national-directory-mental-health-treatment-facilities

Data Source: National Survey of Substance Abuse Treatment Services (N-SSATS) (https://wwwdasis.samhsa.gov/dasis2/nssats.htm)

Brief Description: The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census designed to collect information from all facilities within the 50 States, the District of Columbia, and the U.S. territories, both public and private, that provide substance abuse treatment. N-SSATS provides the mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system.

Examination Components: Designed to collect data based on the location of the facility, the objectives of N-SSATS are (1) Collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements; (2) Update SAMHSA's Inventory of Behavioral Health Services (I-BHS); (3) Analyze general treatment services trends; (4) Generate the online Behavioral Health Treatment Services Locator and the National Directory of Drug and Alcohol Abuse Treatment Programs.

Table 171. National Survey of Substance Abuse Treatment Services (N-SSATS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Substance abuse facilities	Information available	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Two or More Races	N-SSATS collects data about facilities, not individual clients. Data on clients represent an aggregate of clients in treatment for each reporting facility	State	1997-present	Available	Annual

Data Source: National Treatment Improvement Evaluation Study (NTIES) (http://www.icpsr.umich.edu/icpsrweb/NAHDAP/studies/2884)

Brief Description: NTIES inquired about the allocation of grant money to treatment programs, to investigate what improvements were made with these monies and how many and what type of clients were affected by the grant awards. The NTIES project collected longitudinal data on a purposive sample of clients in treatment programs receiving Center for Substance Abuse Treatment (CSAT) demonstration grant funding. Client-level data were obtained at treatment intake, at treatment exit, and 12 months after treatment exit. Service delivery unit (SDU) administrative and clinician (SDU staff) data were obtained at two time points, one year apart. Data were collected across several important outcome areas, including drug and alcohol use, physical and mental health, criminal activity, social functioning, and employment. For a random sample of approximately half of those interviewed, urine specimens were collected at follow-up to corroborate clients' self-reports of substance abuse, in addition to arrest records to validate self-reports. Substances covered in the study included alcohol, analgesics, antianxiety medications, anticonvulsants, antidepressants, antimanics, barbiturates, cocaine (powder and crack), depressants, hallucinogens/psychedelics, heroin and other opiates, illegal methadone, inhalants, marijuana/hashish, methadone, methamphetamine/amphetamine and other stimulants, narcotics, and sedatives.28

Examination Components: NTIES is a congressionally mandated five-year study of the impact of drug and alcohol treatment on thousands of clients in hundreds of treatment units that received public support from SAMHSA, CSAT. At baseline, data were collected on client characteristics (including severity of substance abuse and previous substance abuse treatment experiences), and client perceptions of service needs were collected via interviews. At treatment exit, severity of substance use and service receipt data were collected. At 12 months posttreatment, data on severity of substance abuse (an outcome measure in this study) were again collected. Organizational data were obtained from interviews with treatment program administrators at two points during a 12-month period.

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[28] This study is maintained and distributed by the National Addiction & HIV Data Archive Program (NAHDAP). NAHDAP is supported by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health (NIH).

Table 172. National Treatment Improvement Evaluation Study (NTIES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	All ages	Black, Latino, White	Race, age, years in school, employment status	Cities and regions: Philadelphia, Baltimore, Milwaukee, Atlanta, Chicago, Albuquerque, Los Angeles, Seattle, Cleveland, El Paso, Hartford, Tucson, Boston, The Bronx, Long Island, and portions of Alabama, Arkansas, northern California, Nevada, Oregon, and Wisconsin	1992-1997	The public use data files in this collection are available for access by the general public. Access does not require affiliation with an ICPSR member institution	1992-1997

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 non-compliance rate of no more than 20 percent, 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.

Table 173. State Synar Enforcement Reporting

Target Population	Age	Race & Ethnicity	Socioeconomic 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	N/A	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): http://www.samhsa.gov/synar/annual-reports

Data Source: Treatment Episodes Data Set (TEDS) (https://wwwdasis.samhsa.gov/webt/information.htm)

Brief Description: The TEDS is a minimum data set of demographic and drug history information about individuals admitted to treatment, primarily by providers receiving public funding. States extract these data from their administrative data systems and transmit them to SAMHSA on a regular basis.

Examination Components: The TEDS includes data collected at admission and at discharge, maintained as two separate but linkable data sets. Recently, several new data elements were added to the TEDS data set to provide National Outcome Measures (NOMS). Nearly all states are currently providing the TEDS admission and discharge data (including the NOMS data elements). States not currently submitting both admission and discharge data are expected to begin submitting complete TEDS data in the near future.

Table 174. Treatment Episodes Data Set (TEDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals admitted and discharged for treatment	Information available	White; Black/African American; AI/AN; API; Asian; Two or more races; NHPI; Hispanic; Puerto Rican; Mexican; Cuban; Other specific Hispanic	Source of income	N/A	2006-2014	Publicly available	N/A

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Opioid Epidemic and Relevant Opioid-Related Data Sources

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids, such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. When used correctly under a healthcare provider's direction, prescription pain medicines are helpful. However, misusing prescription opioids risks dependence and addiction. Increased prescription of opioid medications led to widespread misuse of both prescription and non-prescription opioids before it became clear that these medications could indeed be highly addictive.

Prescription drug misuse can have serious medical consequences. Increases in prescription drug misuse over the last 15 years are reflected in increased emergency room visits, overdose deaths associated with prescription drugs, and treatment admissions for prescription drug use disorders, the most severe form of which is an addiction. Overdose deaths involving prescription opioids were five times higher in 2016 than in 1999 (https://www.drugabuse.gov/publications/misuse-prescription-drugs/overview). According to the Centers for Disease Control and Prevention (CDC), more than 140 Americans die from drug overdoses, 91 specifically due to opioids. In 2015, about 52,404 Americans died from drug overdoses, and at least 64,000 died in 2016.

In 2017 the U.S. department of Health and Human Services (HHS) declared a nationwide public health emergency (See https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf) to enable HHS to accelerate temporary appointments of specialized personnel to address the emergency, work with DEA to expand access for certain groups of patients to telemedicine for treating addiction, and provide new flexibilities within HIV/AIDS programs. Concurrently, HHS announced a 5-Point Strategy to Combat the Opioid Crisis. These can be found at https://www.hhs.gov/opioids/ and include:

- Improving access to prevention, treatment, and recovery support services
- Targeting the availability and distribution of overdose-reversing drugs
- Strengthening public health data reporting and collection
- Supporting cutting-edge research on addiction and pain
- Advancing the practice of pain management

In Fiscal Year 2017, HHS invested almost $900 million in opioid-specific funding, including to support state and local governments and civil society groups—to support treatment and recovery services, target availability of overdose-reversing drugs, train first responders, and more. HHS has supported the efforts of the President’s Commission on Combating Drug Addiction and the Opioid Crisis.

Below is a summary of data sources containing relevant information on opioid use to support continued research contributions by those interested and development of further strategies toward prevention, treatment and policies to address the issue.

Data Source: Medical Expenditure Panel Survey (MEPS) (https://meps.ahrq.gov/mepsweb/)

Brief Description: MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of healthcare and health insurance coverage.

Examination Components: MEPS currently has two major components: The Household Component and the Insurance Component. The Household Component provides data from individual households and their members, which is supplemented by data from their medical providers. The Insurance Component is a separate survey of employers that provides data on employer-based health insurance.

The Household Component (HC) collects data from a sample of families and individuals in selected communities across the United States, drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey.

The Insurance Component (IC) collects data from a sample of private and public sector employers on the health insurance plans they offer their employees. The survey is also known as the Health Insurance Cost Study.

Other components include a Medical Provider Component (MPC).

MEPS includes only prescribed drugs purchased in outpatient settings. Prescription medicines administered in an inpatient setting or in a clinic or physician's office are excluded. MEPS uses CAPI, and questions are asked using a recall period of 3–6 months. Data on any opioid use (1 or more prescription fills during year) and with frequent opioid use (4 or more prescription fills or refills during the year) are available in the HC.

Table 175. Medical Expenditure Panel Survey (MEPS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Families, individuals, their medical providers, and employers within the U.S.	Information available	White; Black/African American; AI/AN; Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; Other Asian; Native Hawaiian; Guamanian or Chamorro; Samoan; Other Pacific Islander; Hispanic; Mexican; Mexican American/Chicano; Puerto Rican; Cuban/Cuban American; Dominican; Central or South American; Other Latin American; Other Latin, Hispanic, or Spanish	Annual income; Healthcare expenditure	Census tract	1996-present	Publicly available, data files delayed by one year	Annual

Data Source: National Ambulatory Medical Care Survey (NAMCS) (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: NAMCS is a national survey designed to meet the need for objective, reliable information about the provision and use of ambulatory medical care services in the United States. NAMCS data are used to provide statistics that describe the characteristics of office visits to office-based physicians and CHCs. These include patient demographic characteristics, the conditions most often treated, and the diagnostic and therapeutic services rendered, including medication prescribed.

Examination Components: This survey conducted annually is based on a sample of visits to no federally employed office-based physicians who are primarily engaged in direct patient care. Physicians in the specialties of anesthesiology, pathology, and radiology are excluded from the survey. Data are obtained on patient characteristics, such as age, sex, race, and ethnicity, and visit characteristics, such as patient's reason for visit, physician's diagnosis, services ordered or provided, and treatments, including medication therapy. In addition, data about the physician and his or her practice characteristics are collected as part of a survey induction interview. Data on opioids use from patients are collected through reason of visit, timing, intentional trauma, state of dependence, services provided regarding health education/counseling for substance use.

Table 176. National Ambulatory Medical Care Survey (NAMCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nationally representative survey of office-based physicians and CHC physicians and advance practice providers currently providing ambulatory care, and the patient visits to these providers	Information available	For patient visit data: Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	None for patient	N/A	1973-1981; 1985;1989-present	Public use microdata files or files available at the NCHS Research Data Center (RDC)	Annual

Data Source: National Death Index (NDI) (https://www.cdc.gov/nchs/ndi/index.htm)

Brief Description: NDI is a centralized database of death record information on file in state vital statistics offices.

Examination Components: NDI, a self-supporting service of NCHS, is a component of the National Vital Statistics System. NDI is a centralized database of death record information compiled from state vital statistics offices. The NDI includes all deaths occurring within the U.S. along with cause of death. Recently has been linked with NHCS and NVSS-M-DO datasets to enrich the opioid-specific hospital care and death certificate opioid identification.

Table 177. National Death Index (NDI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	Information available	White; Black/African American; Indian; Chinese; Japanese; Hawaiian; Other non-White; Filipino; Other Asian or Pacific Islander; Hispanic	N/A	State of residence/birth	1979-2016	The fees for routine NDI searches consist of a $350.00 service charge plus $0.15 per user record for each year of death searched	N/A

Data Source: National Health and Nutrition Examination Survey (NHANES) (https://wwwn.cdc.gov/nchs/nhanes/Default.aspx)

Brief Description: NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. NHANES is a major program of NCHS. NCHS is part of the Centers for Disease Control and Prevention (CDC) and has the responsibility for producing vital and health statistics for the Nation.

Examination Components: The survey examines a nationally representative sample of about 5,000 persons each year. These persons are located in counties across the country, 15 of which are visited each year. The NHANES interview includes demographic, socioeconomic, dietary, and health-related questions. The examination component consists of medical, dental, and physiological measurements, as well as laboratory tests administered by highly trained medical personnel. Health interviews are conducted in respondents' homes and data is collected electronically. NHANES includes questions about prescription opioid used in the past 30 days, the length of time of taking opioids, whether the participant take multiple opioids, and the main reason for taking each medication.

Table 178. National Health and Nutrition Examination Survey (NHANES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population of all ages (5,000 persons per year)	Information available	American Indian or Alaska Native; Asian; Black or African American; White; Other; Mexican American, Hispanic/Latino/Spanish Origin or Ancestry	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)	Available	Continuous, with capability for longitudinal follow-up

Data Source: National Health Interview Survey (NHIS) (https://www.cdc.gov/nchs/nhis/index.htm)

Brief Description: NHIS data on a broad range of health topics are collected through personal household interviews. For over 50 years, the U.S. Census Bureau has been the data collection agent for the National Health Interview Survey. Survey results have been instrumental in providing data to track health status, healthcare access, and progress toward achieving national health objectives.

Examination Components: The National Health Interview Survey is a cross-sectional household interview survey. Sampling and interviewing are continuous throughout each year. The sampling plan follows a multistage area probability design that permits the representative sampling of households and non-institutional group quarters (e.g., college dormitories). The sampling plan is redesigned after every decennial census. The current sampling plan was implemented in 2016. It has many similarities to the previous sampling plan, which was in place from 2006 to 2015. The current sampling plan is a sample of clusters of addresses that are located in primary sampling units (PSUs). A PSU consists of a county, a small group of contiguous counties, or a metropolitan statistical area.

The total NHIS sample is subdivided into four separate panels, or subdesigns, such that each panel is a representative sample of the U.S. population. This design feature has a number of advantages, including flexibility for the total sample size. With four sample panels and no sample cuts or augmentations, the expected NHIS sample size (completed interviews) is approximately 35,000 households containing about 87,500 persons.

The NHIS includes several questions about injuries and poisonings that require medical advice or treatment in the past three months, including swallowing a drug or medical substance mistakenly or in overdose.

Table 179. National Health Interview Survey (NHIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Households (42,000 households per year)	Information available	White; Black/African American; Indian (American); Chinese; Filipino; Asian Indian; Other race; Multiple race; Hispanic (Detailed Hispanic group information)	Family and individual income; poverty level, type of living quarters, education, occupation, utilization of healthcare, health insurance, access to care	The current sampling plan is a sample of clusters of addresses that are located in PSUs. A PSU consists of a county, a small group of contiguous counties, or a metropolitan statistical area	1957-present	Available	Annual

Data Source: National Hospital Ambulatory Medical Care Survey (NHAMCS) (https://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm)

Brief Description: NHAMCS is designed to collect data on the utilization and provision of ambulatory care services in hospital emergency and outpatient departments, and in ambulatory surgery centers.

Examination Components: This survey conducted annually is based on a national sample of visits to EDs, outpatient departments (OPDs), and ASLs in non-institutional general and short-stay hospitals, exclusive of federal, military, and Veterans Administration hospitals. Data are obtained on patient characteristics, such as age, sex, race, and ethnicity, and visit characteristics, such as patient's reason for visit, provider's diagnosis, services ordered or provided, and treatments, including medication therapy. Data on opioids use from patients are collected through reason of visit, timing, intentional trauma, state of dependence, services provided regarding health education/counseling for substance use.

Data on visits by patients who use opioids are collected for the following variables: up to five reasons for the visit, up to five diagnoses, type of visit (visit involving injury/trauma), up to 30 medications given in the ED or prescribed at discharge.

Table 180. National Hospital Ambulatory Medical Care Survey (NHAMCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Hospitals within the 50 states and Washington, DC; Patient data collected	Information available	For patient visit data: Hispanic/Latino; White; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native	N/A	State and geographically defined areas	1992-2018	Public use microdata files or files available at the NCHS Research Data Center (RDC)	Annual

Data Source: National Hospital Care Survey (NHCS) (https://www.cdc.gov/nchs/nhcs/index.htm)

Brief Description: NHCS is designed to provide accurate and reliable healthcare statistics that answer key questions of interest to healthcare and public health professionals, researchers, and healthcare policy makers. This includes tracking the latest trends affecting hospitals and healthcare organizations and factors that influence the use of healthcare resources, the quality of healthcare, and disparities in healthcare services provided to population subgroups in the United States.29

Examination Components: NHCS integrates inpatient data formerly collected by NHDS, ED and OPD data collected by the National Hospital Ambulatory Medical Care Survey (NHAMCS), and substance-involved visit data previously collected by DAWN.

The integration of these three surveys allows examination of care provided across treatment settings. It will also be possible to link these survey data to outside data sources, such as the National Death Index to obtain a more complete picture of patient care.

Data are collected on substance-involved in all inpatient discharges, ED, and outpatient department visits for a 12-month period. Data are collected at the encounter level and contain Personal Identifiable Information (PII), which allows users to follow episodes of care across hospital settings, count repeat visits, and link to external data sources, such as the NDI and Medicare data.

Table 181. National Hospital Care Survey (NHCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Hospitals; Patient data collected	Information available	White; Black/African American; AI/AN; Asian; NHPI; Hispanic	NHCS monitors national trends in substance use-related ED visits, including opioid visits. Researchers can link these survey data to outside data sources, such as the National Death Index, to obtain a more complete picture of patient care	Region: Northeast; Midwest; South; West	2011-present	Data from the 2014 NHCS have been successfully linked to the NDI and are now available to researchers through the NCHS Research Data Center	N/A

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[29] Integrates data from several databases, including, NHDS (data collected from: 1965-2010), NAMCS (1973-2018) and the Drug-Abuse Warning Network (DAWN) (1974-2011). Linked data for 2014 includes National Death Index (NDI)] NHDS: National Hospital Discharge Survey; NAMCS: See National Ambulatory Medical Care Survey; DAWN: https://www.samhsa.gov/data/data-we-collect/dawn-drug-abuse-warning-network)

Data Source: National Hospital Discharge Survey (NHDS) (https://www.cdc.gov/nchs/nhds/index.htm [collected ended in 2010, and got integrated into National Hospital Care Survey])

Brief Description: NHDS, which was conducted annually, was a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-federal short-stay hospitals.

Examination Components: Data collected based on ambulatory care and inpatient diagnoses and procedures data, including, but not limited to: Hospital discharges, average length of stay/days of care, first-listed diagnoses, patient characteristics, procedures, hospital inpatient deaths, expected source of payment, delivery and newborn information, detailed diagnoses and procedures. Regarding opioids, refer to information on NHCS (information folded in 2010).

Table 182. National Hospital Discharge Survey (NHDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. Hospitals; Patient data collected	Information available	White; Black/African American; AI/AN; Asian; NHPI; Hispanic	Source of payment	Region: Northeast; Midwest; South; West	1965-2010	Publications, Selected Tables and Reports Available; for data see National Hospital Care Survey	N/A

Data Source: National Impatient Sample (NIS) (https://www.hcup-us.ahrq.gov/nisoverview.jsp)

Brief Description: The NIS is the largest publicly available all-payer inpatient healthcare database in the United States, yielding national estimates of hospital inpatient stays. Its large sample size is ideal for developing national and regional estimates and enables analyses of rare conditions, uncommon treatments, and special populations.

Examination Components: The NIS contains clinical and resource-use information that is included in a typical discharge abstract, with safeguards to protect the privacy of individual patients, physicians, and hospitals (as required by data sources). It contains clinical and non-clinical data elements for each hospital stay, including:

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis, procedure, and external cause of injury codes prior to October 1, 2015
- International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) diagnosis, procedures, and external cause of morbidity codes beginning October 1, 2015
- Patient demographic characteristics (e.g., sex, age, race, median household income for ZIP Code)
- Hospital characteristics (e.g., ownership)
- Expected payment source
- Total charges
- Discharge status
- Length of stay
- Severity and comorbidity measures

NIS is part of a family of databases HCUP. NIS contains hospital discharge data on opioid-related hospital stays with patients' and hospitalization characteristics. Opioid-related hospitalization can be extracted using the ICD-10 system.

Table 183. National Impatient Sample (NIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Seven million hospital stays	Information available	White; Black/African American; Asian or Pacific Islander; Native American; Hispanic; Others	Yes; median household income for zip code	ZIP Code	2012-present	Must purchase access through the Online HCUP Central Distributor	Annual

Data Source: National Survey of Family Growth (NSFG) (https://www.cdc.gov/nchs/nsfg/index.htm)

Brief Description: 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 the U.S. Department of Health and Human Services and others to plan health services and health education programs, and to do statistical studies of families, fertility, and health.

Examination Components: The survey sample is designed to produce national data, not estimates for individual states. NSFG is conducted through in-person interview, with a portion of the more sensitive questions answered privately by self-administration. The interviews are voluntary and confidential. The response rate for recent data releases is around 73 percent. The survey includes a question on illegal drug use only.

Table 184. National Survey of Family Growth (NSFG)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
5,000 men and women, 15-44 of age	Information available	White; Black/African American; Hispanic (including four additional groups); AI/AN; Asian	N/A	N/A	1973-2016; 1973-1995 only women included; 1995-onwards men and women included	Available	Continuous since 2006

Data Source: National Survey of Substance Abuse Treatment Services (N-SSATS) (https://wwwdasis.samhsa.gov/dasis2/nssats.htm)

Brief Description: The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census designed to collect information from all facilities within the 50 States, the District of Columbia, and the U.S. territories, both public and private, that provide substance abuse treatment. N-SSATS provides the mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system.

Examination Components: Designed to collect data based on the location of the facility, the objectives of N-SSATS are (1) Collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements; (2) Update SAMHSA's Inventory of Behavioral Health Services (I-BHS); (3) Analyze general treatment services trends; (4) Generate the online Behavioral Health Treatment Services Locator and the National Directory of Drug and Alcohol Abuse Treatment Programs.

Facility-level data provide an overall count of the annual number of admissions for substance use treatment at all substance use treatment facilities that respond to the census and cannot be used to determine the number of persons who received treatment services in the prior 12 months.

Table 185. National Survey of Substance Abuse Treatment Services (N-SSATS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Substance abuse facilities	Information available	Black or African American; White; Hispanic or Latino (of any race); Native American; Asian or Pacific Islander; Two or More Races	N-SSATS collects data about facilities, not individual clients. Data on clients represent an aggregate of clients in treatment for each reporting facility	State	1997-present	Available	Annual

Data Source: National Survey on Drug Use and Health (NSDUH) (https://nsduhweb.rti.org/respweb/homepage.cfm; http://pdas.samhsa.gov/#/)

Brief Description: NSDUH provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States.

NSDUH is directed by SAMHSA.

Examination Components: The annual survey of the U.S. population ages 12 years or older. The survey is a cross-sectional survey that collects several measures, including: use of illegal drugs, prescription drugs, alcohol, and tobacco; mental disorders, treatment, and co-occurring substance use and mental disorders. Personal interviews with selected households.

The NSDUH provides data on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States. The NSDUH collects data of substance use treatment in the past year with a series of questions about treatment received for alcohol use or illicit drug use (including the non-medical use of prescription type drugs) and information for location, such as a hospital (inpatient), rehabilitation facility (outpatient or inpatient), mental health center, emergency room, private doctor's office, prison or jail, or self-help group.

Table 186. National Survey on Drug Use and Health (NSDUH)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
70,000 respondents	Information available	White; Black/African American; AI/AN; NHPI; Asian; Multiple races; Hispanic	Income, Employment, Housing, Education, health insurance	Based on a small area estimation (SAE) which includes county and subcounty level census data from each state	1971-present	Available	Annual

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

Brief Description: NVDRS contains information on all homicides, suicides, deaths of undetermined intent (including opioid-related deaths of undetermined intent), legal intervention deaths, unintentional firearm deaths.

Examination Components: Data from death certificates, coroner/medical examiner (C/ME) reports (includes toxicology reports), law enforcement reports.

Table 187. National Violent Death Reporting System (NVDRS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
NVDRS is currently in all 50 states, the District of Columbia, and Puerto Rico	All ages and all genders	All races/ethnicities	Occupation, education, and place of residence	NVDRS is currently in all 50 states, the District of Columbia, and Puerto Rico	2003-ongoing (most recent data year available is 2017)	NVDRS Restricted Access Database (RAD) is available for researchers; there are examples of how VDRS states have used data for suicide and homicide prevention; NVDRS data is used by CDC staff for scientific analyses, publications, Epi-Aids; Limited NVDRS data is available through WISQARS: https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jsp	MMWR Surveillance Summaries; for a list of some publications that use NVDRS data please visit: https://www.cdc.gov/violenceprevention/nvdrs/publications.html

Data Source: National Vital Statistics System (NVSS) (https://www.cdc.gov/nchs/nvss/index.htm)

Brief Description: NVSS is an inter-governmental system of sharing data on the vital statistics of the population of the United States.

Examination Components: Data is comprised of registration of vital events – births, deaths, marriages, divorces, and fetal deaths. 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 five territories (Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands).

Data are provided through contracts between CDC's NCHS and vital registration systems that are operated in various jurisdictions and are legally responsible for the registration of vital events, such as births, deaths, marriages, divorces, and fetal deaths. NVSS multiple cause-of death mortality files include underlying cause of death data, which are classified using the ICD-10. Drug poisoning (overdose) death data can be extracted using the ICD-10 system.

Table 188. National Vital Statistics System (NVSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All births (about four million, annually); all deaths (about 2.5 million, annually); reported fetal deaths of 20+ weeks gestation; counts of marriages and divorces	Information available	White; Black; AI/AN; Asian; Hispanic	Source of payment for delivery for some states; education	50 States, 2 cities (Washington, DC, and New York City), and five territories (Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands)	Ranging from 1968-present, depending on the file	Available	Annual

Data Source: Nationwide Emergency Department Sample (NEDS) (https://www.hcup-us.ahrq.gov/nedsoverview.jsp)

Brief Description: NEDS is part of a family of databases and software tools developed for the Healthcare Cost and Utilization Project (HCUP). The NEDS is the largest all-payer ED database in the United States, yielding national estimates of hospital-based ED visits. Unweighted, it contains data from approximately 31 million ED visits each year. Weighted, it estimates roughly 143 million ED visits.

Examination Components: Data from the NEDS include:

- A large sample size, which provides sufficient data for analysis across hospital types and the study of relatively uncommon disorders and procedures
- Discharge data for ED visits from 953 hospitals located in 34 states and the District of Columbia, approximating a 20-percent stratified sample of U.S. hospital-based EDs
- Demographic data, such as hospital and patient characteristics, geographic area, and the nature of ED visits (e.g., common reasons for ED visits, including injuries)
- ED charge information for 85 percent of patients, including individuals covered by Medicare, Medicaid, or private insurance, as well as those who are uninsured
- Children's hospitals with trauma centers, which are classified with adult and pediatric trauma centers in the current versions of the NEDS.

Starting on Oct 2015, NEDS includes ICD-10-CM/PCS diagnoses, procedure, and external cause of morbidity codes. Drug poisoning (overdose) death data can be extracted using the ICD-10 system.

Table 189. Nationwide Emergency Department Sample (NEDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Inpatients (adult and children) at hospitals within the U.S.	Information available	Not available for some states	National quartile of median household income for patient's ZIP Code	Urban-rural designation of residence	2006-2015	Available for purchase through the HCUP Central Distributor	N/A

Data Source: Youth Risk Behavior Surveillance System (YRBSS) (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm?s_cid=tw-zaza-1171)

Brief Description: The YRBSS was developed in 1990 to monitor health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include:

- Behaviors that contribute to the unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

Examination Components: The YRBSS includes national, state, territorial, tribal government, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States. The state, territorial, tribal government, and local surveys, conducted by departments of health and education, provide data representative of mostly public high school students in each jurisdiction. Data on drug use include ever use or current use (during the past 30 days), of pain medicines without a doctor’s prescription.

Table 190.   Youth Risk Behavior Surveillance System (YRBSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
9th through 12th grade students in public, Catholic, and private schools in the U.S.	Information available	White; Black/African American; AI/AN; Asian; NHPI; Hispanic	N/A	N/A	1991 – present. Collected on a biannual basis except in 1990	Available	N/A

Data Source: Treatment Episodes Data Set (TEDS) (https://wwwdasis.samhsa.gov/webt/information.htm)

Brief Description: TEDS compiles client-level data for substance abuse treatment admissions from State Agency data systems. State data systems collect data from facilities about their admissions to treatment and discharges from treatment. TEDS is an admission-based system, but it does not include all admissions.

Examination Components: The TEDS includes data collected at admission and at discharge, maintained as two separate but linkable data sets. Recently, several new data elements were added to the TEDS data set to provide National Outcome Measures (NOMS). Nearly all states are currently providing the TEDS admission and discharge data (including the NOMS data elements). States not currently submitting both admission and discharge data are expected to begin submitting complete TEDS data in the near future.

Admission data collected on substance use includes principal source of referral; primary, secondary, and tertiary substance problems and their usual route of administration, frequency of use, and age of first use; and planned use of medication-assisted opioid therapy. TEDS also provides an overall count of the annual number of admissions for substance use treatment at facilities, including outpatient, residential, and hospital inpatient facilities.

Table 191. Treatment Episodes Data Set (TEDS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Individuals admitted and discharged for treatment	Information available	White; Black/African American; AI/AN; API; Asian; Two or more races; NHPI; Hispanic; Puerto Rican; Mexican; Cuban; Other specific Hispanic	N/A	N/A	Treatment episode data were first collected in 1973 through 1981 on annual basis under a different name; data collection was discontinued in 1981; TEDS began in 1989 and is collected annually	Publicly available	N/A

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Access to Collections of Restricted Use

Biorepository Samples and Related Data Collections

Data Repositories

Imaging Repositories

The National Institutes of Health (NIH) conduct and fund research involving clinical studies that generate valuable collections of biospecimens and related clinical data. These collections result from studies addressing biological, behavioral and medical sciences, including clinical trials testing preventive and therapeutic interventions on a variety of conditions. These collections are built over many years from studies that carefully selected subjects and are available in a finite quantity. These collections are valuable and mostly maintained by the federal government through its biorepositories. Over the years, study collections have made significant contributions to public health and will continue to do so. They are also relevant to study disparities in health and healthcare.

NIH Sharing Policies (https://grants.nih.gov/policy/sharing.htm) are that the results and accomplishments of the activities that it funds are to be made available to the research community and to the public at large. Access to these collections, however, is more controlled, requiring submissions and obtaining approval of research proposals requesting and justifying the use of such collections. Scientific merit of the proposals as well as the value and availability of biospecimens and related data are critical elements in the review process of such proposals. NIH institutes that run a biorepository have established their own standard operating procedures and specific policies. Material and Transfer Agreements are established to allow access to the resources. Below are brief descriptions to numerous NIH Bio and/or Data Repositories, most of which store collections from studies supported by extramural grants or both extra and intramural research. Links are provided to take the reader to a list of studies collections available at each of the Bio and/or Data Repositories.

Table 192. Repositories

Repository	Description
AgingResearchBiobank https://agingresearchbiobank.nia.nih.gov/	The National Institute on Aging (NIA) conducts and funds various longitudinal and clinical studies on aging that generate or have generated a collection of biospecimens and related phenotypic and clinical data. In 2018, the NIA's Division of Geriatrics and Clinical Gerontology established the AgingResearchBiobank to provide a state-of-the-art inventory system for the storage and distribution of these collections to the broader scientific community. Aging research can be expanded using such collections to address new promising scientific questions targeting the development of prognostics, markers, and therapeutics for conditions related to aging and to provide a better understanding of the aging process. Together with the opportunity to potentially pool data across study collections

Repository	Description
	significantly increases the value and power of future research findings from the resources offered by the AgingResearchBiobank. The link below provides access to information on study collections currently available. https://agingresearchbiobank.nia.nih.gov/studies/
Biologic Specimen and Data Repository Coordinating Center (BioLINCC), NHLBI https://biolincc.nhlbi.nih.gov/home/	NHLBI Biologic Specimen and Data Repository is the coming together of two entities: the NHLBI Biologic Specimen Repository (NHLBI Biorepository), managed by the NHLBI, Division of Blood Diseases and Resources (DBDR), Transfusion Medicine and Cellular Therapeutics Branch, and the NHLBI Data Repository, managed by the NHLBI, Division of Cardiovascular Sciences (DCVS), Epidemiology Branch. The aim is to enhance and facilitate further research in cardiovascular, pulmonary and hematologic conditions by providing access to qualified investigators to stored biospecimen and data collections. The link below provides access to a list of all studies with resources available for searching and request via BioLINCC. Keywords and study properties can be used to perform a search and retrieve relevant information about a study, biospecimen and clinical data availability. https://biolincc.nhlbi.nih.gov/studies/
Central Repository, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) https://repository.niddk.nih.gov/home/	NIDDK established data and specimen repositories to increase the impact of current and previously funded NIDDK studies by making their data and biospecimens available to the broader scientific community. This enables investigators not involved in the original study to test new hypotheses without any new data or biospecimen collection and provides the opportunity to pool data across several studies to increase the power of statistical analyses. Most NIDDK-funded studies are collecting genetic biospecimens and carrying out high-throughput genotyping making it possible for other scientists to use repository resources to match genotypes to phenotypes and to perform informative genetic analyses. The link below provides access to search capabilities for study resources. Studies marked as “Internal Use Only” provide access to samples via collaboration only. https://repository.niddk.nih.gov/search/study/
National Cancer Institute https://biospecimens.cancer.gov/default.asp	The NCI at NIH Biorepositories and Biospecimen Research Branch (BBRB) strives to standardize the consistency and quality of biospecimens collected for use by investigators in research through the development and deployment of standard procurement and research standards. These facilitate Biospecimen Science studies that form the basis of evidence-based practices to guide clinical cancer research and other biomedical studies which utilize biospecimens. The link below provides access to search mechanism of biospecimens research database:

Repository	Description
	https://brd.nci.nih.gov/brd/advanced-search
Data and Specimen Hub (DASH), Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) https://dash.nichd.nih.gov/	DASH is a centralized resource for researchers to store de-identified data and to access data and associated biospecimens from NICHD supported studies for use in secondary research. The links below provide access to search mechanisms for studies, data and biospecimens: • https://dash.nichd.nih.gov/studyExplorer • https://dash.nichd.nih.gov/datasetExplorer • https://dash.nichd.nih.gov/biospecimenExplorer
Human Genetics Resource Center, National Institute of Neurological Disorders and Stroke (NINDS)	NINDS is committed to gene discovery, as a strategy for identifying the genetic causes and correlates of nervous system disorders. The NINDS Human Genetics Resource Center banks samples from subjects with cerebrovascular disease, dystonia, epilepsy, motor neuron disease, Parkinsonism and Tourette Syndrome, as well as population controls. The following link provides access to information on the NINDS available collections and instructions on how to obtain access to these resources: https://www.coriell.org/1/NINDS
NeuroBiobank, NINDS	The NeuroBioBank, supported by the NIMH, NINDS, and NICHD was established in September 2013 as a national resource for investigators utilizing human post-mortem brain tissue and related biospecimens for their research to understand conditions of the nervous system. With specimens that span neurological, neuropsychiatric, and neurodevelopmental diseases and disorders, the NeuroBioBank serves as a central point of access to the world-class collections of our five network sites. In addition, the NeuroBioBank provides researchers with a wealth of resources to facilitate their research, including medical records and clinical data sets (when available) as well as access to quality metrics and Standard Operating Procedures (SOPs) used by each site. The link below provides access to scientific resources offered by the NeuroBioBank: https://www.ninds.nih.gov/Current-Research/Scientific-Resources/CellTissueDNA
BioSEND Human Biomarkers Biospecimen and Data Repository, NINDS	Indiana University became the home of the NINDS biomarker repository in September of 2015. The newly renamed repository, named BioSEND, houses biospecimens collected as part of biomarker studies supported by the NINDS. The goal of BioSEND is to bank and distribute biological samples that can be used to identify biomarkers of disease susceptibility, onset and progression. These biomarker studies are focused on Parkinson's disease (PD), Huntington's disease (HD), Lewy Body Dementia (LBD), Frontotemporal Dementia (FTD), and other neurological and neuropsychiatric diseases. BioSEND currently banks a variety of biospecimens, including DNA, plasma, serum, RNA, CSF, and saliva from numerous different studies.

Repository	Description
	The link below provides more information on the NINDS BioSEND: https://www.biosend.org/history.html
Neuroimaging Tools and Resources Collaboratory (NITRC), Funded by NIH Blueprint for Neuroscience Research, National Institute of Biomedical Imaging and Bioengineering (NIBIB), National Institute of Drug Addiction (NIDA), National Institute of Mental Health (NIMH) and NINDS	NITRC's scientific focus includes: PET/SPECT, CT, EEG/MEG, optical imaging, clinical neuroinformatics, computational neuroscience, and imaging genomics software tools, data, and computational resources. Components: • NITRC – R Resources Registry • NITRC-IR NITRC Image Repository • NITRC-CE NITRC Computational Environment With NITRC and its components—the Resources Registry (NITRC-R), Image Repository (NITRC-IR), and Computational Environment (NITRC-CE)—a researcher can obtain pilot or proof-of-concept data to validate a hypothesis. The following link provides access to additional information: https://www.nitrc.org/include/about_us.php
Database of Genotypes and Phenotypes (dbGaP) https://www.ncbi.nlm.nih.gov/gap/	National Center for Biotechnology Information, U.S. National Library of Medicine, hosts the database of Genotypes and Phenotypes (dbGaP), which was developed to archive and distribute the data and results from studies that have investigated the interaction of genotype and phenotype in Humans. The link below provides access to the list of collections under dbGaP: https://www.ncbi.nlm.nih.gov/projects/gap/cgi-bin/GetCollectionList.cgi The link below also provides access to the policies and procedures to controlled access to the data: https://dbgap.ncbi.nlm.nih.gov/aa/wga.cgi?page=login
All of Us https://allofus.nih.gov/	The *All of Us* Research Program is a major component of the Precision Medicine initiative. It is a historic effort by NIH to gather data from one million or more people living in the United States to accelerate research and improve health. By considering individual differences in lifestyle, environment, and biology, researchers will likely uncover paths toward delivering precision medicine. In 2019 two distinct funding opportunities for engagement and communications partners was issued to support the program. The respective awardees will work with *All of Us* as the program seeks to create one of the most comprehensive and diverse biomedical data resources of its kind by recruiting and retaining one million or more participants from across the country who reflect the country's rich diversity. The following is a link to the All of US Research Hub, providing access to data currently available, including data snapshots and sources: https://www.researchallofus.org/

U.S. ENVIRONMENTAL PROTECTION AGENCY

Data Source: Air Data (Air Quality Data Collected at Outdoor Across the U.S.) (https://www.epa.gov/outdoor-air-quality-data)

Brief Description: Provides access to outdoor air quality data collected from state, local and tribal monitoring agencies across the United States.

Examination Components: Key components: carbon monoxide, ozone, lead, nitrogen dioxide, particulate matter (also known as particle pollution), and sulfur dioxide.

Table 193. Air Data (Air Quality Data Collected at Outdoor Across the U.S.)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Monitoring stations throughout the U.S.	N/A	N/A	N/A	Latitude and longitude, city, county, state, tribe	Starting January 1, 1980 to present	Air Quality Data available at https://www.epa.gov/outdoor-air-quality-data	Available technical and summary reports at https://www.epa.gov/outdoor-air-quality-data

Data Source: Air Quality System (AQS) Datamart (https://aqs.epa.gov/aqsweb/documents/data_mart_welcome.html)

Brief Description: The AQS Data Mart is a database containing all the information from the AQS system. The AQS Data Mart was built as a storehouse of air quality information that allows users to make queries of unlimited quantities of data. The Data Mart also includes information from the EPA's substance and facility registry systems to allow for cross-media integration.

Examination Components: Key components: carbon monoxide, ozone, lead, nitrogen dioxide, particulate matter (also known as particle pollution), and sulfur dioxide.

Table 194. Air Quality System (AQS) Datamart

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Monitoring stations throughout the U.S.	N/A	N/A	N/A	Latitude and longitude, city, county, state, tribe	Starting January 1, 1980 to present	Available at https://aqs.epa.gov/aqsweb/documents/data_mart_welcome.html	Available

Data Source: Air Quality System (AQS) (https://www.epa.gov/aqs)

Brief Description: The AQS database contains measurements of air pollutant concentrations from throughout the United States and its territories. The measurements include both criteria air pollutants and hazardous air pollutants

Examination Components: Key components include ambient air pollution data collected by EPA, state, local, and tribal air pollution control agencies from thousands of monitoring stations, meteorological data, and descriptive information about each monitoring station (including its geographic location).

Table 195. Air Quality System (AQS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Populations in proximity to monitoring stations	N/A	N/A	N/A	Latitude and longitude, city, county, state, tribe	Starting January 1, 1980 to present	Available at https://www.epa.gov/aqs How to obtain data available at https://www.epa.gov/aqs/obtaining-aqs-data	Air Quality Data available at https://www.epa.gov/outdoor-air-quality-data

Data Source: AirCompare (http://www.epa.gov/aircompare/)

Brief Description: AirCompare contains air quality information that allows a user to compare conditions in different localities over time and compare conditions in the same location at different times of the year.

Examination Components: Air quality information.

Table 196. AirCompare

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	Asthma, heart disease, age, outdoors	Counties, State	Most recent year, 2012	Available at http://www.epa.gov/aircompare/	Annual

Data Source: AirNow (http://airnow.gov/)

Brief Description: AirNow is a collaboration between EPA, and other federal, state and local agencies to provide complete and real-time air quality information.

Examination Components: Key components: Ozone, PM2.5.

Table 197. AirNow

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Monitoring stations throughout the U.S.	N/A	N/A	N/A	State, zip code	Most detailed data from 1999 to present	Available at http://airnow.gov/	Available

Data Source: Enforcement & Compliance History Online (ECHO) (https://echo.epa.gov/)

Brief Description: ECHO allows searches for facilities in communities to assess their compliance with environmental regulations.

Examination Components: Key components: permit, inspection, violation, enforcement action, and penalty information about facilities regulated under various federal environmental acts.

Table 198. Enforcement & Compliance History Online (ECHO)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Approximately 800,000 EPA-regulated facilities nationwide	N/A	N/A	Demographics surrounding facilities	Zip code, city	Varies; mostly from 2002	Available at https://echo.epa.gov/	Available

Data Source: Envirofacts (http://www.epa.gov/enviro/index.html)

Brief Description: Envirofacts website provides access to several EPA databases with information about environmental activities that may affect air, water, and land anywhere in the United States.

Examination Components: Key components: air, water, and land data.

Table 199. Envirofacts

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All	N/A	N/A	N/A	Zip code, city, county, state	Ranges for each data set	Data downloads available at http://www.epa.gov/enviro/index.html Systems data search available at https://www.epa.gov/enviro/system-data-searches	Available. The 2017 Toxic Release Inventory (TRI) National Analysis report is available at www.epa.gov/trinationalanalysis

Data Source: Environmental Monitoring and Assessment Program (EMAP) National Coastal Database (http://www.epa.gov/emap/index.html)

Brief Description: The EMAP National Coastal Database contains estuarine and coastal data that EMAP and Regional-EMAP have collected. Note: This data source is now only available for historical reference.

Examination Components: Key components: water column data, sediment contaminants and toxicity data, and benthic macroinvertebrate and demersal fish community and contaminant data.

Table 200. Environmental Monitoring and Assessment Program (EMAP) National Coastal Database

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Stations along the U.S. coasts	N/A	N/A	N/A	N/A	Starting in 1990. Note: EMAP is now only available for historical reference	Available at http://www.epa.gov/emap/index.html	Available

Data Source: Facility Registry System (FRS) (http://www.epa.gov/enviro/html/fii/index.html)

Brief Description: FRS provides an integrated source of comprehensive environmental information about facilities across EPA, states, tribes and other "places" of environmental interest, such as schools and landfills.

Examination Components: Key components: air, water, and waste data.

Table 201. Facility Registry System (FRS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Facilities	N/A	N/A	N/A	Zip code	Varies according to data source	Available at http://www.epa.gov/enviro/html/fii/index.html	Available

Data Source: Integrated Risk Information System (IRIS) (https://www.epa.gov/iris)

Brief Description: The IRIS database contains information on more than 550 chemical substances and the human health effects that might result from exposure to these substances. An IRIS assessment supports the first two steps of a human health risk assessment, that is hazard identification, which identifies credible health hazards associated with exposure to a chemical, and providing a dose-response assessment, which characterizes the quantitative relationship between chemical exposure and each credible health hazard. These quantitative relationships are then used to derive cancer and non-cancer toxicity values which are then posted to the database.

Examination Components: Key components: toxicity values for non-cancer reference concentrations (RfC), reference dose (RfD) effects; and cancer effects for oral slope factor (OSF) and inhalation unit risk (IUR). IRIS studies are vetted through a rigorous process using HERO, systematic review and then peer reviewed to ensure they meet agency standards.

Table 202. Integrated Risk Information System (IRIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All	N/A	N/A	N/A	N/A	Starting in 1985 to present	Available at http://www.epa.gov/iris/	Available. IRIS program update schedule available at https://www.epa.gov/iris/iris-program-outlook

Data Source: RadNet (http://www.epa.gov/radnet/)

Brief Description: RadNet is a national network of more than 200 monitoring stations distributed across all 50 states and the American Territories. Each station regularly samples the nation's air, precipitation, drinking water, or pasteurized milk for a variety of radionuclides (e.g., iodine-131) and radiation types (e.g., gross beta (b)).

Examination Components: Key components: radionuclides (e.g., iodine-131) and radiation types (e.g., gross beta (b).

Table 203. RadNet

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
200 Monitoring stations	N/A	N/A	N/A	RadNet air monitoring and sampling stations are widely distributed across the entire U.S.	Varies according to data source	Available at http://www.epa.gov/radnet/	The near real-time air monitoring data are continually reviewed by computer and are usually posted to EPA's Central Data Exchange website within 2 hours of arriving at the laboratory

Data Source: Safe Drinking Water Information System (SDWIS) (http://www.epa.gov/enviro/facts/sdwis/search.html)

Brief Description: SDWIS contains information about public water systems and their violations of EPA's drinking water regulations.

Examination Components: Key components: drinking water supplier, violations and enforcement history.

Table 204. Safe Drinking Water Information System (SDWIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Public water systems, states	N/A	N/A	N/A	Geography search by state and a water system ID search	1993 to present	Available at http://www.epa.gov/enviro/facts/sdwis/search.html	Annual

Data Source: Storage and Retrieval for Water Quality Data (STORET) (http://www.epa.gov/storet/)

Brief Description: Storage and Retrieval for Water Quality Data (STORET) is a repository for water quality, biological, and physical data.

Examination Components: Key components: biological, habitat, and chemical data.

Table 205. Storage and Retrieval for Water Quality Data (STORET)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	N/A	Zip code, State/County, Latitude/Longitude, Hydrologic Unit, Station Type	Since the early 1960s; many components	Available at http://www.epa.gov/storet/	Refreshed weekly

Data Source: Toxic Release Inventory (TRI) (https://www.epa.gov/toxics-release-inventory-tri-program)

Brief Description: TRI is a database containing detailed information on nearly 650 chemicals and chemical categories that approximately 22,000 industrial and federal facilities manage through disposal or other releases, or recycling, energy recovery, or treatment.

Examination Components: Key components: 650 chemicals and chemical categories that approximately 22,000 industrial and federal facilities.

Table 206. Toxic Release Inventory (TRI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	N/A	Zip code, State/County, tribe	Since 1986 to present	Available at http://www2.epa.gov/toxics-release-inventory-tri-program	Annual

Data Source: Water Quality Assessment and Total Maximum Daily Loads Information (ATTAINS) (https://www.epa.gov/waterdata/attains)

Brief Description: The Water Quality Assessment TMDL Tracking and Implementation System (ATTAINS) stores and tracks state water quality assessment decisions, Total Maximum Daily Loads (TMDLs) and other watershed plans designed to restore impaired waters.

Examination Components: Water quality conditions.

Table 207. Water Quality Assessment and Total Maximum Daily Loads Information (ATTAINS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	N/A	State, watershed	Since 2002 to present	Available at https://www.epa.gov/waterdata/attains	Every other even year

Data Source: Watershed Assessment, Tracking & Environmental ResultS (WATERS) (http://water.epa.gov/scitech/datait/tools/waters/index.cfm)

Brief Description: WATERS is an integrated information system for the nation's surface waters connecting Office of Water databases to a larger network of water information.

Examination Components: Nation's surface waters.

Table 208. Watershed Assessment, Tracking & Environmental ResultS (WATERS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	N/A	N/A	N/A	State, region	Varies according to data source	Available at http://water.epa.gov/scitech/datait/tools/waters/index.cfm	Varies according to data source

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Data Source: Food Access Research Atlas (FARA) (https://www.ers.usda.gov/data-products/food-access-research-atlas.aspx)

Brief Description: FARA presents a spatial overview of food access indicators for low-income and other census tracts using different measures of supermarket accessibility; provides food access data for populations within census tracts; and offers census tract level data on food access that can be downloaded for community planning or research purposes.

Examination Components: Population data, including age, race, Hispanic ethnicity, and residence in group quarters, are from the 2010 Census of the Population and downloaded at the census-block level before being allocated to ½-kilometer-square grid cells. Urban or rural designation was also provided by the 2010 Census at the block level. Data on income, vehicle availability, and SNAP participation are from the 2010-14 American Community Survey and were downloaded at the block group level (income and vehicle availability) and tract level (SNAP participation) for assignment to ½-kilometer-square grid cells. Two 2015 lists of supermarkets, supercenters, and large grocery stores were combined to produce a comprehensive list of stores that represent sources of affordable and nutritious food. One store list contains stores authorized to receive SNAP benefits. The second list is from Trade Dimensions TDLinx (a Nielsen company), a proprietary source of individual supermarket store listings. Details on these data sources can be found in the USDA, ERS report, Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015.

Table 209. Food Access Research Atlas (FARA)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Neighborhoods that are low-income and lack healthy food sources	All ages	All races/ethnicities	Race, Age, Income and Poverty Rate	Census tract	2006, 2010, and 2015	Available from the ERS website: https://www.ers.usda.gov/data-products/food-access-research-atlas/	In addition to the data available in FARA, data is also available in the 2017 report, Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 and the 2012 report, Access to Affordable and Nutritious Food: Updated Estimates of Distance to Supermarkets Using 2010 Data. The FARA has also been used in a wide range of research reports

Data Source: Food Environment Atlas (https://www.ers.usda.gov/data-products/food-environment-atlas/)

Brief Description: The Food Environment Atlas assembles statistics on food environment indicators—such as store/restaurant proximity, food prices, food and nutrition assistance programs, and community characteristics— to stimulate research on the determinants of food choices and diet quality, and provides a spatial overview of a community's ability to access healthy food and its success in doing so.

Examination Components: The Atlas currently includes over 275 indicators of the food environment. These indicators are separated into three categories: Food Choices—Indicators of the community's access to and acquisition of healthy, affordable food, such as: access and proximity to a grocery store; number of food stores and restaurants; expenditures on fast foods; food and nutrition assistance program participation; food prices; food taxes; and availability of local foods; Health and Well-Being—Indicators of the community's success in maintaining healthy diets, such as: food insecurity; diabetes and obesity rates; and physical activity levels; and Community Characteristics—Indicators of community characteristics that might influence the food environment, such as: demographic composition; income and poverty; population loss; metro/non-metro status; natural amenities; and recreation and fitness centers. The year and geographic level of the indicators vary to better accommodate data from a variety of sources. Some indicators are at the county level while others are at the State or regional level.

Table 210. Food Environment Atlas

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
N/A	All ages	All races/ethnicities	Race, Age, Income and Poverty Rate, Metro/non-metro counties, and population-loss counties	Regional, State, and County	Varies depending on data source	Available from the ERS website: https://www.ers.usda.gov/data-products/food-environment-atlas//	N/A

Data Source: Supplemental Nutrition Assistance Program (SNAP) Policy Database (https://www.ers.usda.gov/data-products/snap-policy-database.aspx)

Brief Description: The SNAP Policy Database provides a central data source for information on State policy options in the Supplemental Nutrition Assistance Program (SNAP). The database draws on policy information from a wide variety of sources, including surveys by USDA's Food and Nutrition Service (FNS), national and State policy research organizations, State policy manuals, and news articles.

Examination Components: The database includes information on State-level SNAP policies relating to eligibility criteria, recertification and reporting requirements, benefit issuance methods, availability of online applications, use of biometric technology (such as fingerprinting), and coordination with other low-income assistance programs. The information in this database can be used to: (1) describe the differences in the State-level administration of SNAP and trends in the adoption of specific State-level SNAP policies, (2) examine how State policies affect household-level participation in SNAP, and (3) estimate the effect of SNAP participation on outcomes, such as health and food spending, by combining this data with nationally representative survey data. The SNAP Policy Database provides a potentially exogenous source of variation in program participation and can be used in instrumental variables estimation techniques.

Table 211. Supplemental Nutrition Assistance Program (SNAP) Policy Database

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Information comes from secondary sources about state administration of the Supplemental Nutrition Assistance Program	N/A	N/A	N/A	State	1996-2016	Available from the ERS website at: https://www.ers.usda.gov/data-products/snap-policy-database.aspx	The SNAP Policy Database is used in the ERS 2018 report, *Using a Policy Index to Capture Trends and Differences in State Administration of USDA's Supplemental Nutrition Assistance Program*, and has been used in a wide range of research reports

Data Source: Cost Estimates of Foodborne Illness (CEFI) (https://www.ers.usda.gov/data-products/cost-estimates-of-foodborne-illnesses/)

Brief Description: The Cost Estimates of Foodborne Illnesses data product provides detailed data about the costs of 15 major foodborne illnesses in the United States. Per case and total national cost estimates are provided. Data is provided to update these estimates annually for inflation and income growth.

Examination Components: The Cost Estimates of Foodborne Illnesses data product includes cost of illness estimates for: Campylobacter, Clostridium perfringens, Cryptosporidium parvum, Cyclospora cayetanensis, E. coli O157, non-O157 STEC, Listeria monocytogenes, Norovirus, Salmonella (non-typhoidal), Shigella, Toxoplasma gondii, Vibrio parahaemolyticus, and Yersinia enterocolitica. Disease outcome trees are included for each pathogen. Disease outcomes may include non-hospitalized cases who do not seek medical care; non-hospitalized cases who seek medical care; hospitalized cases of varying severity; chronic illnesses (where data adequately supports, including chronic conditions); deaths. Severity of illnesses and therefore disease outcomes included, vary by pathogen. Cases, per case cost and total cost are reported for each pathogen-specific disease outcome and for the pathogen. Cost components include cost of medical treatment, lost wages due to illness, and societal willingness to pay to reduce preventable deaths in the U.S. population. Case numbers are based on the most recent CDC estimates of the incidence of foodborne disease in the U.S. and peer-reviewed disease outcome modeling. Data is provided to update cost estimates for inflation and income growth over time.

Table 212. Cost Estimates of Foodborne Illness (CEFI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
National	N/A	N/A	N/A	National	Base year estimates provided for 2013. Consumer price index and income data are annual starting with 2013.	Available from the ERS website: https://www.ers.usda.gov/data-products/cost-estimates-of-foodborne-illnesses/	This data is revised on a 5-year basis. The next revision is due out in 2020.

Data Source: Current Population Survey Food Security Supplement (CPS-FSS) (https://www.ers.usda.gov/data-products/food-security-in-the-united-states/ or https://thedataweb.rm.census.gov/ftp/cps_ftp.html#cpssupps)

Brief Description: The Current Population Survey Food Security Supplement (CPS-FSS) is the source of national and state-level statistics on food insecurity used in USDA's annual reports on household food security. The CPS is a monthly labor force survey of about 50,000 households conducted by the Census Bureau for the Bureau of Labor Statistics. Once each year, after answering the labor force questions, the same households are asked a series of questions (the Food Security Supplement) about food security, food expenditures, and use of food and nutrition assistance programs. Food security data have been collected by the CPS-FSS each year since 1995.

Examination Components: CPS includes labor force and demographic information for all respondents. The Food Security Supplement includes measures of food security, along with food spending, and participation in federal and community food and nutrition assistance programs. The food security supplement asked one adult respondent per household questions about experiences and behaviors that indicate food insecurity, such as being unable to afford balanced meals, cutting the size of meals, or being hungry because of too little money for food. The food security status of the household was assigned based on the number of food-insecure conditions reported. Food-insecure households had difficulty at some time during the year providing enough food for all their members due to a lack of resources.

Table 213. Current Population Survey Food Security Supplement (CPS-FSS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nationally representative	All ages	All races/ethnicities	Race, Age, Education, Employment, Disability Status, Family Structure, Income, and Metro/non-metro counties	MSAs and states if multiple years of data are combined to ensure a large enough sample for reliable estimates	1995-current	All years are publicly available	Annual reports are published by the Economic Research Service of USDA in the series *Household Food Security in the United States.* https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us.aspx

Data Source: Eating and Health Module (EHM) of the American Time Use Survey (ATUS) (https://www.ers.usda.gov/data-products/eating-and-health-module-atus/)

Brief Description: USDA's Economic Research Service, along with its funding and technical assistance cosponsors—FNS and NCI—worked with the Bureau of Labor Statistics (BLS) and the Census Bureau to collect data for the 2014-16 Eating & Health Module (EH Module), a supplement to the ATUS. The 2014-16 EH Module asks ATUS respondents about secondary eating—that is, eating while doing another activity; soft drink consumption; grocery shopping preferences and fast food purchases; meal preparation and food safety practices; food assistance participation; general health, height and weight, and exercise; and income.

Examination Components: ERS's 2006-08 EH Module produced statistics on time spent in eating and drinking activities, grocery shopping, and meal preparation for the population age 15 and older and for participants in SNAP. Data were also presented on measures of the health status (such as BMI) of the population by time spent in various activities. For a complete description of the questions asked in the module visit https://www.ers.usda.gov/data-products/eating-and-health-module-atus/module-questions/

Table 214. Eating and Health Module (EHM) of the American Time Use Survey (ATUS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
N/A	15 and older/ All	All races/ethnicities	The module can be linked to the ATUS and to CPS that collects household characteristics (e.g., number of persons living in the household), and individual characteristics (e.g., age, education, employment, race, etc.)	CPS collects a geography variable to identify a household location (e.g., Federal Information Processing Standard (FIPS) State code)	2006-08 and 2014-16 (six years in total)	Available from the ERS website: https://www.ers.usda.gov/data-products/eating-and-health-module-atus/	N/A

Data Source: National Household Food Acquisition and Purchase Survey (FoodAPS) (http://www.ers.usda.gov/foodaps)

Brief Description: The National Household FoodAPS collected information on foods purchased or otherwise acquired, and the prices and nutrient characteristics of those foods, for a nationally representative sample of U.S. households. Data on factors expected to affect food acquisition decisions, such as household size and composition, demographic characteristics, income, participation in federal food assistance programs, and dietary restrictions, were also collected.

Examination Components: FoodAPS includes over 900 variables in 11 distinct datasets. The Primary Respondent was asked to complete two in-person interviews and to complete three brief telephone interviews regarding food acquisition events. Each household member age 11 years and older was asked to track and report all food acquisitions during the 1-week period. Households were asked to scan barcodes on foods, save their receipts from stores and restaurants, and write information in their food books. At the household level, data on household composition, employment and income, expenses, food security, diet, health, and nutrition, household financial condition, and distance to primary food stores is available. Individual-level data include demographic and employment information, school attendance and nutrition program participation, food allergies, income, and health status. Detailed nutrient information on food items were appended to the data.

Table 215. National Household Food Acquisition and Purchase Survey (FoodAPS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The survey had four target groups, defined in terms of participation in the SNAP and total reported household income: Households receiving SNAP benefits; Non-SNAP households with income less than the poverty guideline; Non-SNAP households with income greater than or equal to 100 percent and less than 185 percent the poverty guideline; and Non-SNAP households with income greater or equal to 185 percent of the poverty guideline	All ages	All races/ ethnicities	Employment, education, income, age, sex, ethnicity, and marital status	Varies depending on need. Not available in public use due to disclosure risk. Researchers with justified need may access the restricted-use data geography component that includes data at the block group, census tract, and county level, for researchers who seek to use more aggregated food environment measures. The data describe the food environment of the surveyed households	April 2012 – January 2013	Public use data available here: http://www.ers.usda.gov/foodaps Information on applying for access to the restricted-use data available here: https://www.ers.usda.gov/data-products/foodaps-national-household-food-acquisition-and-purchase-survey/data-access/	N/A

Data Source: Food Availability (Per Capita) Data System (https://www.ers.usda.gov/data-products/food-availability-per-capita-data-system/)

Brief Description: The Data System has three distinct but related data series on food and nutrient availability for consumption based on U.S. supply and use data.

Examination Components: The data include estimates for over 200 commodities. Available commodity supply (production + imports + beginning stocks) – Measurable non-food use (farm inputs + exports + ending stocks, etc.) = Total annual food supply of a commodity.

Table 216. Food Availability (Per Capita) Data System

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S population	All ages	All races and ethnicities	N/A	National level	Annual – 1909-2015 depending on the commodity	Available to the public	Annual reports. Reports are available to the public

Data Source: Atlas of Rural and Small-Town America (https://www.ers.usda.gov/data-products/atlas-of-rural-and-small-town-america/)

Brief Description: The Atlas of Rural and Small-town America provides basic county-level mapping, and downloadable data on demographic and social characteristics of all U.S. counties. The indicators available are from publicly available government sources, such as the Census Bureau, the Bureau of Labor Statistics, and USDA. These indicators are commonly used to assess rural and counties.

Examination Components: People, Jobs, USDA ERS County Classifications, Income, and Veterans.

Table 217. Atlas of Rural and Small-Town America

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
N/A	All ages	All races/ethnicities	The Atlas includes county-level data on income, education, and poverty. Also, induced are the USDA ERS county economic type and policy classification indicator variables	County	The data ranges from 2000 to the most current. The Atlas is updated several times each year with the most current data available. Older data is retained when replaced	Available for use. See https://www.ers.usda.gov/data-products/atlas-of-rural-and-small-town-america/	N/A

Data Source: Flexible Consumer Behavior Survey (FCBS) Module of the National Health and Nutrition Examination Survey (NHANES) (https://www.ers.usda.gov/topics/food-choices-health/food-consumption-demand/flexible-consumer-behavior-survey/)

Brief Description: The FCBS is a consumer behavior module in NCHS's NHANES. The survey collects information on U.S. consumers' knowledge, attitudes, and beliefs about nutrition and food choices.

Examination Components: The FCBS collects information on two broad categories of interest to ERS. First, economic measures, such as monthly income, assets, food expenditures, and participation in food and nutrition assistance programs, such as SNAP or WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Second, dietary and behavioral indicators, such as self-assessed diet quality, types of foods available in the home, frequency of eating out, time spent grocery shopping and time spent cooking meals at home, nutritional knowledge, use of food labels while grocery shopping and use of nutrition information when eating out, and the importance of price, convenience, and taste when grocery shopping or eating out.

Table 218. Flexible Consumer Behavior Survey (FCBS) Module of the National Health and Nutrition Examination Survey (NHANES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Nationally representative	All ages	Mexican American, Other Hispanic, Non-Hispanic White, Non-Hispanic Black, Other Race (including Multiracial)	Race/Ethnicity, Age, Sex, Education, Income, Assets, Employment Status, and Marital Status	National level	2007-2016	2007-2014 are available for public use	After each FCBS cycle is available for public use, a summary of the new data is posted on ERS's FCBS topic page

Data Source: Supplemental Nutrition Assistance Program (SNAP) Quality Control Data (https://host76.mathematica-mpr.com/fns/)

Brief Description: The SNAP Quality Control Data is a cross-sectional sample of economic and demographic characteristics of SNAP households.

Examination Components: It is a sample of representative households selected in each state. Primary purpose of dataset is payment accuracy but includes detailed demographic and economic information about households.

Table 219. Supplemental Nutrition Assistance Program (SNAP) Quality Control Data

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
SNAP households	All ages	All races and ethnicities	Income sources and employment	State level	Annual – 1980s to present	Available to public	Annual report on data Characteristics of SNAP Households

Data Source: Supplemental Nutrition Assistance Program (SNAP) Program Data (https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap)

Brief Description: The SNAP Program Data has monthly aggregate counts at state level of participating individuals, households, and benefit issuance.

Examination Components: The SNAP program data includes participants, households, and benefits.

Table 220. Supplemental Nutrition Assistance Program (SNAP) Program Data

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
SNAP households	Includes all ages but data not broken out by age	All races and ethnicities but data not broken out by race and ethnicity	N/A	State level	Annual – 1960s to present	Available to public	Monthly

U.S. DEPARTMENT OF COMMERCE

U.S. Census Bureau

Data Source: Current Population Survey (CPS) Annual Social and Economic Supplement (http://www.census.gov/cps/about/)

Brief Description: CPS, sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS) and fielded by the U.S. Census Bureau. The CPS 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. The CPS Annual Social and Economic Supplement is an annual survey sponsored by the U.S. Census Bureau that includes additional detail on annual work activity, income, health insurance, and health.

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 19th of the month. The questions refer to activities during the prior week; that is, the week that includes the 12th 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.

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 non-students. 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. 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.

Table 221. Current Population Survey (CPS) Annual Social and Economic Supplement

Target Population	Age	Race & Ethnicity	Socioeconomic 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, non-family; householder; income measurement; income-to-poverty ratios, mean (average) income; median income; metropolitan-non-metropolitan 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: http://www.census.gov/cps/about/	Periodic reports available at: https://www.census.gov/main/www/cprs.html

Data Source: American Community Survey (ACS) (https://www.census.gov/programs-surveys/acs/)

Brief Description: ACS is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's decennial census program. The ACS collects information, such as age, race, income, commute time to work, home value, Veteran status, disability, and other important data.

Examination Components: Each year the ACS randomly samples around 3.5 million addresses and produces statistics that cover 1-year and 5-year periods for geographic areas in the United States and Puerto Rico.

Table 222. American Community Survey (ACS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian non-institutionalized population; group quarters information also collected	All age groups. No gender restriction.	Black; White; Asian; Other; Hispanic	Income; education; employment; marital status	Census Tract	2008-2016	Available at https://dataferrett.census.gov/AboutDatasets/ACS.html	Available at https://www.census.gov/programs-surveys/acs/library/publications-and-working-papers/reports.html

Data Source: Survey of Income and Program Participation (SIPP) (https://www.census.gov/sipp/)

Brief Description: SIPP is the premier source of information for income and program participation. SIPP collects data and measures change for many topics, including economic well-being, family dynamics, education, assets, health insurance, childcare, disability, healthcare utilization, medical expenditures and food security.

Examination Components: SIPP is a nationally representative panel survey administered by the Census Bureau that collects information on the short-term dynamics of employment, income, household composition, and eligibility and participation in government assistance programs. Each SIPP Panel follows individuals for several years, providing monthly data that measures changes in household and family composition and economic circumstances over time.

Table 223. Survey of Income and Program Participation (SIPP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian Non-Institutionalized	All age groups. Adults 15 and older eligible for individual interview; persons under 15 have information collected by proxy. No gender restriction	Black; White; Asian; Other; Hispanic	Income; education; employment; marital status; program participation, including SNAP, WIC, TANF, General Assistance	National	2014-2018; Previous SIPP Panels going back to 1983	Available at https://www.census.gov/sipp/	Available at https://www.census.gov/sipp/

U.S. DEPARTMENT OF JUSTICE

Bureau of Justice Statistics

Data Source: National Prisoner Statistics (NPS) Program (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=269)

Brief Description: Data are collected annually from the 50 state departments of corrections (DOC) and the Bureau of Prisons (BOP). NPS collects national- and state-level data on the number of prisoners held in state and federal prison facilities. Aggregate data are collected on race and sex of prison inmates, inmates held in private facilities and local jails, system capacity, non-citizens, and persons age 17 or younger. Findings are released in the Bureau of Justice Statistics (BJS) Prisoners series and the BJS Corrections Statistical Analysis Tool (CSAT) – Prisoners.

Examination Components: Information is collected on the number of prisoners (total and by sex) known to have HIV/AIDS in a jurisdiction and jurisdiction's HIV testing policies for inmates in state and federal prison systems at time of admission, while in custody, and at time of release.

Table 224. National Prisoner Statistics (NPS) Program

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Persons held in state or federal prison facilities	Adults ages 18 and older. Limited data on persons age 17 or younger	Categories have varied over time. See the methodology and changes over time sections on the survey's home page for details	Prevalence of people with HIV/AIDS in state or federal prison facilities	50 state DOCs and the BOP	NPS data annual since 1926 HIV/AIDS data have been collected annually since 1999	Available via the National Archive of Criminal Justice Data (NACJD) NPS webpage https://www.icpsr.umich.edu/icpsrweb/NACJD/series/886; and the BJS Corrections Statistical Analysis Tool (CSAT) – Prisoners https://www.bjs.gov/index.cfm?ty=nps	NPS data are available on the survey's home page Data on HIV in prisons are published in a series available at https://www.bjs.gov/index.cfm?ty=pbse&sid=7 or www.bjs.gov

Data Source: 2011 National Survey of Prison Health Care (NSPHC) (https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5705 or https://www.cdc.gov/nchs/dhcs/nsphc.htm)

Brief Description: The 2011 NSPHC was cooperatively developed and conducted by BJS and the Centers for Disease Control's (CDC) National Center for Health Statistics. The survey aimed to conduct semi-structured telephone interviews with respondents from all 50 state DOC and the Federal BOP. Interviews were conducted in 2012 for calendar year 2011. The level of participation varied by state and questionnaire item.

Examination Components: Admissions testing for infectious disease, cardiovascular risk factors, and mental health conditions; the provision of medical and mental health services by type of services delivered; the location of medical and mental health services (i.e., off prison grounds) and utilization of telemedicine are included.

Table 225. 2011 National Survey of Prison Health Care (NSPHC)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Prison facility healthcare services	N/A	N/A	N/A	State DOCs and the BOP	2011	Available via the CDC's survey home page https://www.cdc.gov/nchs/dhcs/nsphc.htm	Available on the survey's home page.

Data Source: Survey of Inmates in Federal Correctional Facilities (SIFCF) (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=273) and the Survey of Inmates in State Correctional Facilities (SISCF) (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=275) (collectively renamed the Survey of Prison Inmates in 2016).

Brief Description: The SIFCF and SISCF surveys were conducted concurrently through personal interviews with a nationally representative sample of inmates held in state or federally owned and operated facilities. The surveys utilized a two-stage sample design in which prisons were selected in the first stage and inmates within prisons were selected in the second stage. Self-reported data were collected on a wide range of personal, offense, and criminal justice characteristics.

Examination Components: Self-reported data on demographic characteristics, Veteran status, current offense and sentence length, characteristics of victims of violent crimes, criminal histories, family background, current parental status, prior drug and alcohol use, alcohol and drug use treatment while incarcerated, lifetime medical and mental health problems, current medical and mental health problems and treatment while incarcerated, participations in educational program or services while in prison, as well as many other personal and criminal justice characteristics.

Table 226. Survey of Inmates in Federal Correctional Facilities (SIFCF) and the Survey of Inmates in State Correctional Facilities (SISCF)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults in state or federal prison	Ages 18 and older	Categories changed over time. See survey questionnaire or methodology for information. (Published reports display more limited racial and ethnic categories than the questionnaires)	Education status; marital status; pre-incarceration work and income status; pre-incarceration living status; childhood and family background characteristics (i.e., foster care placement)	State or federal prison	SIFCF – 1991, 1997, 2004 SISCF – 1974, 1979,1986, 1991, 1997, and 2004	Available via the NACJD survey webpage https://www.icpsr.umich.edu/icpsrweb/NACJD/series/70	Reports are available on the BJS website

Data Source: Survey of Prison Inmates (SPI), formerly called the SIFCF and SISCF (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=488)

Brief Description: The SPI is a periodic, cross-sectional survey of the state and sentenced federal prison populations. Its primary objective is to produce national statistics of the state and sentenced federal prison populations across a variety of domains. From January through October 2016, data were collected through face-to-face interviews with prisoners using CAPI.

Examination Components: Self-reported data on demographic characteristics, demographic characteristics, current offense and sentence, incident characteristics, firearm possession and sources, criminal history, socioeconomic characteristics, family background, drug and alcohol use and treatment, mental and physical health and treatment, and facility programs and rule violations. Physical health problems include measures of infectious diseases, chronic conditions (i.e., diabetes), and disabilities.

Table 227. Survey of Prison Inmates (SPI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults in state or federal prison	Ages 18 and older	Respondents can select all that apply from White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, other race. Spanish, Latino, or Hispanic origin	Education status; marital status; pre-incarceration work and income status; pre-incarceration living status; childhood and family background characteristics (i.e., foster care placement)	State or federal prison	2016	Data will be available via the NACJD survey webpage	Reports are available on the survey's home page

Data Source: Survey of Inmates in Local Jails (SILJ) (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=274)

Brief Description: Conducted periodically, the survey provides information on people held in jail. Data are collected through personal interviews with a nationally representative sample of inmates in local jails. The survey utilized a two-stage sample design in which jails were selected in the first stage and inmates within local jails were selected in the second stage.

Examination Components: Individual characteristics of jail inmates, current offenses and detention status, characteristics of victims, criminal histories, family background, gun possession and use, prior drug and alcohol use and treatment, medical and mental health history and treatment, vocational programs and other services provided while in jails, as well as other personal characteristics.

Table 228. Survey of Inmates in Local Jails (SILJ)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults held in local jails	Ages 18 and older	Race and ethnicity measures changed over time. See the methodology or questionnaire for the year of interest for details.	Education status; marital status; pre-incarceration work and income status; pre-incarceration living status; childhood and family background characteristics (i.e., foster care placement)	Local jails	1972, 1978, 1983, 1989, 1996 and 2002 Updated data are expected in the early 2020s	Data are available via the NACJD survey webpage https://www.icpsr.umich.edu/icpsrweb/NACJD/series/69	Reports are available via the survey's home page

Data Source: National Crime Victimization Survey (NCVS) (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=245)

Brief Description: Each year, data are obtained from a nationally representative sample of about 240,000 interviews on criminal victimization, involving 160,000 unique persons in about 95,000 households. Persons are interviewed on the frequency, characteristics, and consequences of criminal victimization in the United States. The NCVS collects information on non-fatal personal crimes (i.e., rape or sexual assault, robbery, aggravated and simple assault, and personal larceny) and household property crimes (i.e., burglary, motor vehicle theft, and other theft) both reported and not reported to police. A school crime supplement (SCS) to the NCVS has been conducted periodically since 1999 and collects information about school-related victimization on a national level.

Examination Components: Survey respondents provide information about themselves (e.g., age, sex, race and Hispanic origin, marital status, education level, and income) and whether they experienced a victimization. For each victimization incident, the NCVS collects information about the offender (e.g., age, race and Hispanic origin, sex, and victim-offender relationship), characteristics of the crime (e.g., time and place of occurrence, use of weapons, nature of injury, and economic consequences), whether the crime was reported to police, reasons the crime was or was not reported, and victim experiences with the criminal justice system. The SCS collects data on student characteristics, participation in after-school activities, students' perceptions of school rules and enforcement, students' perceptions of safety in different school-based locations, bullying, the presence of gangs in schools, and attitudinal questions relating to the fear of victimization at school.

Table 229. National Crime Victimization Survey (NCVS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Persons 12 or older	Persons 12 or older	Race and ethnicity measures changed over time, see the methodology or questionnaire for the year of interest for details	Marital status, education level, income	Household level	Annually since 1973	NCVS data are available to the public on the NACJD survey home page https://www.icpsr.umich.edu/icpsrweb/NACJD/series/95	Available on the BJS survey's home page

Data Source: National Inmate Survey (NIS) (https://www.bjs.gov/index.cfm?ty=dcdetail&iid=278)

Brief Description: NIS is part of BJS's National Prison Rape Statistics Program, which gathers mandated data on the incidence and prevalence of sexual assault in correctional facilities under the Prison Rape Elimination Act of 2003 (PREA; P.L. 108 – 79). PREA requires a 10 percent sample of correctional facilities to be listed by incidence of sexual assault, with a minimum of one prison and one jail facility in each state. Data are collected directly from inmates in a private setting using audio computer-assisted self-interview (ACASI) technology with a touchscreen laptop and an audio feed to maximize inmate confidentiality and minimize literacy issues. See the methodology section in reports for sampling and weighting information.

Examination Components: Inmates were randomly assigned to receive either a survey of sexual victimization or an alternative survey of mental and physical health, past drug and alcohol use, and treatment for substance abuse (questions from which are also used to pad out time for respondents completing the victimization survey quickly). Respondents who completed the sexual victimization survey in less than the allotted time of 35 minutes were eligible to receive the alternative modules.

Table 230. National Inmate Survey (NIS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Adults in prison or jail	Ages 18+	Respondents can select all that apply from White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, other race Spanish, Latino, or Hispanic origin	Marital status, pre-incarceration income and employment, education, Veteran status	Facility level	2007, 2008-09, 2011-12, additional data are expected in the early 2020s	Not available	Reports are available on the survey home page, including special reports on health topics

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Data Source: Public Housing Developments (https://egis-hud.opendata.arcgis.com/datasets/5c96143f79c940a0a8cedae99a1ac562_0)

Brief Description: Public Housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single-family houses to high-rise apartments for elderly families. There are approximately 1.2 million households living in public housing units, managed by some 3,300 housing agencies (HAs). HUD administers federal aid to local HAs that manage the housing for low-income residents at rents they can afford.

Examination Components: Geospatial data that describes the location and household composition of public housing developments.

Table 231. Public Housing Developments

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Low-income families assisted by HUD's public housing program	Household composition by development. For example, the percent of households headed by female	Household composition by development. For example, the percent of households headed by minorities	A large amount of household-level income information. For example: Average Total Household Income per Year, Percent of Households with Income Below 5,000 per Year, and Percent of Households with Income Below 30 Percent of Local Area Median Family	Block group level FIPS Codes	2017 (Updated bi-annually)	Publicly available	Updated bi-annually

Data Source: Public Housing Buildings (https://egis-hud.opendata.arcgis.com/datasets/52a6a3a2ef1e4489837f97dcedaf8e27_0)

Brief Description: Public Housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single-family houses to high-rise apartments for elderly families. There are approximately 1.2 million households living in public housing units, managed by some 3,300 Housing Agencies (HAs). HUD administers federal aid to local HAs that manage the housing for low-income residents at rents they can afford. HUD furnishes technical and professional assistance in planning, developing and managing these developments.

Examination Components: Geospatial data that describes the location and household composition of public housing buildings. Public Housing Developments are depicted as a distinct address chosen to represent the general location of an entire Public Housing Development, which may be comprised of several buildings scattered across a community. The building with the largest number of units is selected to represent the location of the development.

Table 232. Public Housing Buildings

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Low-income families assisted by HUD's public housing program	Household composition by development. For example, the percent of households headed by female	Household composition by development. For example, the percent of households headed by minorities	A large amount of household-level income information. For example: Average Total Household Income per Year, Percent of Households with Income Below 5,000 per Year, and Percent of Households with Income Below 30 Percent of Local Area Median Family	Block group level FIPS Codes	Current as of: 09/30/2016	Publicly available	Updated annually

Data Source: Public Housing Authorities (https://egis-hud.opendata.arcgis.com/datasets/3d6ef39026b94eb59ddb7ce28eb0b692_0)

Brief Description: Public Housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single-family houses to high-rise apartments for elderly families. There are approximately 1.2 million households living in public housing units, managed by over 3,300 Housing Agencies (HAs). HUD administers federal aid to local HAs that manage the housing for low-income residents at rents they can afford. HUD furnishes technical and professional assistance in planning, developing and managing these developments. Public Housing Authorities are depicted as the physical location. Location data for HUD-related properties and facilities are derived from HUD's enterprise geocoding service.

Examination Components: Geospatial data that describes the location of local and state housing authorities. Dataset also describes attributes of service.

Table 233. Public Housing Authorities

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Low-income families assisted by HUD's public housing and Housing Choice Voucher program	Number of children, elderly, disabled served	N/A	Program-specific income information. For example, program type and vacancy information	Block group level FIPS Codes	Data Current as of 03/2017	Publicly available	Updated annually

Data Source: Housing Choice Vouchers (HCV) by Tract (https://egis-hud.opendata.arcgis.com/datasets/8d45c34f7f64433586ef6a448d00ca12_0)

Brief Description: The U.S. Department of Housing and Urban Developments (HUD) Housing Choice Voucher Program (HCVP) is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants can find their own housing, including single-family homes, townhouses and apartments. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers (HCV) are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from HUD to administer the voucher program. A family that is issued a housing voucher is responsible for finding a suitable housing unit of the family's choice where the owner agrees to rent under the program. This unit may include the family's present residence. Rental units must meet minimum standards of health and safety, as determined by the PHA. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home.

Examination Components: HCV locations are identified in public records by the owner and not the tenant so access to this information is restricted to help safeguard the location of HCV units. Due to the sensitive nature of the HCV locations, these are aggregated to the 2010 Census Tract geography.

Table 234. Housing Choice Vouchers (CHV) by Tract

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Low-income families assisted by HUD's HCVP	N/A	N/A	N/A	Tract	Data is current as of 09/30/2016	Publicly available	Updated annually

Data Source: The Affirmatively Furthering Fair Housing Data and Mapping Tool (AFFH-T) (https://www.hudexchange.info/resource/4867/affh-data-and-mapping-tool/)

Brief Description: The Affirmatively Furthering Fair Housing Data and Mapping Tool (AFFH-T) is publicly available and for use by program participants to access HUD-provided data to conduct the fair housing analysis required as part of the Assessment of Fair Housing.

Examination Components: HUD has asked its program participants to take a more serious look at their fair housing context. The agency is taking a more active role as a dynamic partner by providing data and analytical tools to help grantees quantify and interpret fair housing dynamics. HUD provides a dynamic online mapping and data-generating tool for communities to aid in their completion of the Assessment of Fair Housing using the Assessment Tool. HUD accompanies this tool with guidance tailored to accommodate program participants of all capacity levels.

Table 235. The Affirmatively Furthering Fair Housing Data and Mapping Tool (AFFH-T)

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The AFFH-T includes data for all U.S. states, the District of Columbia, and Puerto Rico	The Fair Housing Act prohibits housing discrimination against any person based on sex. The AFFH-T provides information on male/female status	Among other protected characteristics, the Fair Housing Act prohibits housing discrimination based on race. HUD offers data on both race and ethnicity. HUD provides data for non-Hispanic Whites, considering Hispanics of any race as a separate race/ethnic category that can experience housing discrimination differently than other groups. Similarly, the data provided for the other race groups – Black, Asian and Pacific Islander, Native American, and other – also exclude information for people who identify their ethnicity as Hispanic	Low Poverty Index	Data displayed in the AFFH-T map views are at the census tract level for local governments and for PHAs, and at the county level for states. Data displayed in the report tables are aggregated from smaller geographic units (i.e., either the census tract or block group level) to the CDBG2 and CBSA, PHA Service Area, county, State entitlement and non-entitlement areas, and state levels	Published September 2017	Publicly available	N/A

Data Source: HUD Person-Level and Household-Level Administrative Longitudinal File: Rental Assistance Programs (https://www.huduser.gov/portal/research/pdr_data-license.html)

Brief Description: Household-level and/or member-level administrative data from HUD’s housing rental assistance programs, including public housing, housing choice vouchers, and multifamily housing (including project-based section 8).

Examination Components: Administrative data available represents elements collected via the Form HUD-50058, Form HUD-50058 MTW, and Form HUD-50059.

Table 236. HUD Person-Level and Household-Level Administrative Longitudinal File: Rental Assistance Programs

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Data for all U.S. states, the District of Columbia, and Puerto Rico	Person-level file contains gender and age	Person-level file contains race/ethnicity	Granular income information at the household and person level	Unit, Latitude/Longitudinal	1995-present	Only Available via HUD Data License Process	Updated Quarterly

Data Source: Multifamily Properties Assisted (https://egis-hud.opendata.arcgis.com/datasets/83d334f8b4614cce9e67b0e0a1105520_0)

Brief Description: HUD Multifamily Housing property portfolio consist primarily of rental housing properties with five or more dwelling units, such as apartments or town houses, but can also be nursing homes, hospitals, elderly housing, mobile home parks, retirement service centers, and occasionally vacant land. The portfolio can be broken down into two basic categories: insured and assisted. HUD provides subsidies and grants to property owners and developers designed to promote the development and preservation of affordable rental units for low-income populations and those with special needs, such as the elderly and disabled. The three largest assistance programs for Multifamily housing are Section 8 Project-Based Assistance, Section 202 Supportive Housing for the Elderly, and Section 811 Supportive Housing for Persons with Disabilities.

Examination Components: Geospatial data that describes the location of multifamily properties.

Table 237. Multifamily Properties Assisted

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Low-income families assisted by HUD's multifamily housing programs	Household composition by property. For example, the percent of households headed by female	Household composition by development. For example, the percent of households headed by minorities	A large amount of household-level income information. For example: Average Total Household Income per Year, Percent of Households with Income Below 5,000 per Year, and Percent of Households with Income Below 30 Percent of Local Area Median Family	Block group level FIPS Codes	Data Current as of: 06/30/2016	Publicly available	Updated annually

Data Source: Low-Income Housing Tax Credit (LIHTC) (https://egis-hud.opendata.arcgis.com/datasets/907edabaf7974f7fb59beef14c4b82f6_0)

Brief Description: Created by the Tax Reform Act of 1986, the Low-Income Housing Tax Credit program (LIHTC) gives State and local LIHTC-allocating agencies the equivalent of nearly $8 billion in annual budget authority to issue tax credits for the acquisition, rehabilitation, or new construction of rental housing targeted to lower-income households. Although some data about the program have been made available by various sources, HUD's database is the only complete national source of information on the size, unit mix, and location of individual projects. With the continued support of the national LIHTC database, HUD hopes to enable researchers to learn more about the effects of the tax credit program.

Examination Components: Geospatial data that describes the location of LIHTC buildings.

Table 238. Low-Income Housing Tax Credit (LIHTC)

Target Population	Age/Gender	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Data for all U.S. states, the District of Columbia, and Puerto Rico	Indicator to assess if property prioritizes families, elderly, etc.	N/A	Number of low-income units	Block group level FIPS Codes	Data is current as of 06/2017	Publicly available	Updated annually

Data Source: NCHS-HUD Linked Data (https://www.cdc.gov/nchs/data-linkage/hud.htm)

Brief Description: NCHS has linked 1999-2016 National Health Interview Survey (NHIS) and 1999-2016 NHANES to administrative data through 2016 for HUD's largest housing assistance programs: the Housing Choice Voucher program, public housing, and privately owned, subsidized multifamily housing. Linkage of NCHS survey participants with HUD administrative records provides the opportunity to examine relationships between housing and health. Data access requires submission of application submitted via the Research Data Center at CDC/NCHS. Update biannually.

Examination Components: All NHIS and NHANES components available during 1999-2016 survey cycles.

Note: For further information, refer to this compendium section under "Centers for Disease Control and Prevention, National Center for Health Statistics" on "Overview of NCHS Data Linkage Initiative."

U.S. DEPARTMENT OF EDUCATION

Data Source: National Assessment of Educational Progress (https://nces.ed.gov/nationsreportcard/; National Assessment of Educational Progress (NAEP) Data Explorer: https://www.nationsreportcard.gov/ndecore/landing)

Brief Description: NAEP is the largest nationally representative and continuing assessment of what America's students know and can do in various subject areas.

Examination Components: Assessments are conducted periodically in mathematics, reading, science, writing, the arts, civics, economics, geography, U.S. history, and in Technology and Engineering Literacy (TEL). Assessments are conducted most frequently for reading and mathematics (every two years for grades 4 and 8). In conjunction with these assessments, surveys are also administered to students, their teacher, and their school administrators. Data is collected regarding Socioeconomic status as well as student absenteeism (student self-reported).

Table 239. National Assessment of Educational Progress (NAEP)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Grade 4, 8, and 12 students. Their teachers and their school administrators also complete a survey as part of the assessment	Grade 4, 8, and 12 students	American Indian/Alaska Native, Asian, Black, Hispanic, Pacific Islander, and White (data has only recently broken out Asian and Pacific Islander into two groups). Some pre-2017 assessments do not have AI/AN reportable data	National School Lunch Program Status (School Records); proxy variables (e.g., items in the home) from the NAEP student questionnaires; and additional National School Program Status and Title I questions from the NAEP school questionnaires	Varies by assessment, grade, and year of assessment. State-level data is available / federally mandated for reading and mathematics (grades 4 and 8)	Assessments are conducted virtually every year	Available via the NAEP Data Explorer	Reports are publicly released for all NAEP assessments

Data Source: National Indian Education Study (NIES) (https://nces.ed.gov/nationsreportcard/nies/; National Indian Education Study (NIES) Data Explorer: https://www.nationsreportcard.gov/ndecore/landing)

Brief Description: NIES presents the performance results of American Indian and Alaska Native (AI/AN) students at grades 4 and 8 on the NAEP in reading and mathematics.

Examination Components: NIES is administered to grade 4 and 8 students in conjunction with the NAEP assessments in reading and mathematics. NIES school survey asks several health-related questions regarding available services for students within the school (e.g., health services for students, such as a school nurse, school or counseling services for students) as well as to what extent various topics are a problem in the school (e.g., student health problems).

Table 240. National Indian Education Study (NIES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
American Indian / Alaska Natives (AI/AN) students. Their teachers and their school administrators also complete a survey as part of the study	Grade 4 and 8 students	American Indian / Alaska Natives	Sources of funding (NIES School Questionnaire); National School Lunch Program Status (School Records); proxy variables (e.g., items in the home) from the NAEP student questionnaires; and National School Program Status and Title I questions from the NAEP school questionnaires	Data is available for the nation and select states with enough AI/AN students to meet reporting standards	Every 2 years from 2005 – 2011; every 4 years starting in 2015	Available via the NIES Data Explorer	Available via the study's home page

Data Source: National Household Education Surveys Program (NHES) (https://nces.ed.gov/nhes/)

Brief Description: NHES provides descriptive data on the educational activities of the U.S. population and offers researchers, educators, and policymakers a variety of statistics on the condition of education in the United States. The NHES surveys cover learning at all ages, from early childhood to school age through adulthood.

Examination Components: Multiple surveys are administered as part of NHES, including the following in 2016: Early Childhood Program Participation (ECPP) and Parent and Family Involvement in Education (PFI). Both surveys have a specific section regarding child's health as well as questions about receiving specific benefits (e.g., Temporary Assistance for Needy Families, Medicaid, Child Health Insurance Program).

Table 241. National Household Education Surveys Program (NHES)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children from birth to age 6 and not yet in kindergarten	Respondents are parents of children from birth to age 6 and not yet in kindergarten	American Indian/Alaska Native, Asian, Black, Hispanic, Pacific Islander, and White	Household income (categorical variable)	Region. NHES is nationally representative only	1991, 1995, 1999, 2001, 2005, 2007, 2012, 2016	Public use files on website	ED TAB or First Look reports released with all data files

Data Source: Early Childhood Longitudinal Program (ECLS) (https://nces.ed.gov/ecls/)

Brief Description: The Early Childhood Longitudinal Study (ECLS) program includes three longitudinal studies that examine child development, school readiness, and early school experiences. The birth cohort of the ECLS-B is a sample of children born in 2001 and followed from birth through kindergarten entry. The kindergarten class of 1998-99 cohort (ECLS-K) is a sample of children followed from kindergarten through the eighth grade. The kindergarten class of 2010-11 cohort (ECLS-K:2011) followed a sample of children from kindergarten through the fifth grade. The ECLS program provides national data on children's status at birth and at various points thereafter; children's transitions to non-parental care, early education programs, and school; and children's experiences and growth through the eighth grade. The ECLS program also provides data to analyze the relationships among a wide range of family, school, community, and individual variables with children's development, early learning, and performance in school.

Examination Components: ECLS-B: Children, their parents, their childcare and early education providers, and their teachers provided information on children's cognitive, social, emotional, and physical development across multiple settings (e.g., home, childcare, school). Additionally, information on children's elementary schools is available by linking the ECLS-B data to school data from the National Center for Education Statistics (NCES's) Common Core of Data (CCD) and Private School Survey (PSS) universe files, which pertain to U.S. public and private schools, respectively. ECLS-K: Children, their families, their teachers, and their schools provided information on children's cognitive, social, emotional, and physical development. Information on children's home environment, home educational activities, school environment, classroom environment, classroom curriculum, and teacher qualifications also were collected. ECLS-K:2011: Children, their families, teachers, schools, and care providers provided information on children's cognitive, social, emotional, and physical development. Information was also collected on children's home environment, home educational activities, school environment, classroom environment, classroom curriculum, teacher qualifications, and before- and after-school care.

Table 242. Early Childhood Longitudinal Program (ECLS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Children born in the U.S. in 2001	Birth to kindergarten entry	American Indian or Alaska Native, Asian, Black or African American, Hispanic, Native Hawaiian or Other Pacific Islander, and White	Household income (categorical variable), parents' education level, parents' occupation	Region. Zip codes as well as county and state information for the study child's household and childcare center/provider are available. The sample is not representative of children in particular states (or cities or counties)	2001-02, 2003-02, 2005-06, fall 2006, fall 2007	Case-level data only available on restricted-use files; a subset of variables from the 9-month data collection is available to the general public in the Data Analysis System (DAS)	First Look reports were released with all data files

Data Source: Educational Longitudinal Study of 2002 (ELS: 2002) (https://nces.ed.gov/surveys/els2002/)

Brief Description: The focus of ELS:2002 is on: 1) students' trajectories from the beginning of high school into postsecondary education, the workforce, and beyond; and 2) the different patterns of college access and persistence that occur in the years following high school completion.

Examination Components: ELS:2002 features include: 1) Nationally representative, longitudinal study of 10th graders in 2002 and 12th graders in 2004; 2) students are followed throughout secondary and postsecondary years; 3) surveys of students, their parents, math and English teachers, and school administrators; 4) student assessments in math (10th & 12th grades) and English (10th grade); and 5) high school transcripts available for research on course taking. Basic elements that are encompassed in the ELS:2002 research instruments can be classified in three broad categories: background information (normally collected in the base year only), process information (information about dynamic influences on the student, in the home, school, and community environment, as he or she moves through secondary school and beyond into the world of postsecondary education and the adult workforce), and outcome information (the eventual outcomes of the transition process). ELS:2002 data collections include information on race, family income, parent education & employment, health history, school climate / safety, and socioemotional development.

Table 243. Educational Longitudinal Study of 2002 (ELS: 2002)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The U.S. sophomore class of 2001-02 and the senior class of 2003-04 as they progressed through high school and until 2012	10th grade or 12th grade through 25-26	American Indian or Alaska Native, Asian, Black or African American, Hispanic, Native Hawaiian or Other Pacific Islander, and White	Socioeconomic status composite made up of: Household income, parents' education level, parents' occupation	Region. Census tract and zip codes for schools are available. The sample is not representative of students in particular states (or cities or counties)	Spring 2002, Spring 2004, 2005 (HS transcripts)	The U.S. sophomore class of 2001-02 and the senior class of 2003-04 as they progressed through high school and until 2012	10th grade or 12th grade through 25-26

Data Source: High School Longitudinal Study of 2009 (HSLS: 09) (https://nces.ed.gov/surveys/hsls09/)

Brief Description: The focus of HSLS: 09 is on students' trajectories from the beginning of high school into postsecondary education, the workforce, and beyond; 2) majors and careers students decide to pursue when, why, and how; and 3) how students choose science, technology, engineering, and math (STEM) courses, majors, and careers.

Examination Components: HSLS: 09 features include: 1) Nationally representative, longitudinal study of 23,000+ 9th graders from 944 schools in 2009, with a first follow-up in 2012 and a second follow-up in 2016; 2) students are followed throughout secondary and postsecondary years; 3) surveys of students, their parents, math and science teachers, school administrators, and school counselors; 4) a new student assessment in algebraic skills, reasoning, and problem solving for 9th and 11th grades; and 5) 10 state-representative datasets. While it is not the central focus of the study, some student health-related information is collected (e.g., parent questionnaire asks if their child has been diagnosed by a doctor for a variety of different health conditions).

Table 244. High School Longitudinal Study of 2009 (HSLS: 09)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The U.S. ninth grade class of 2009-10 as they progressed through high school and (tentatively) until 2025	9th grade through 20-21, tentatively through age 30	American Indian or Alaska Native, Asian, Black or African American, Hispanic, Native Hawaiian or Other Pacific Islander, and White	Socioeconomic status composite made up of: Household income, parents' education level, parents' occupation	Region. Census tract and zip codes for schools are available. The sample is not representative of students in particular cities or counties, though there are 10 state-representative sets that are part of this dataset (FL, GA, NY, TN, OH, PA, CA, NC, MI, TX)	Fall 2009, Spring 2012, 2013, 2014 (HS transcripts), 2016	The U.S. ninth grade class of 2009-10 as they progressed through high school and (tentatively) until 2025	9th grade through 20-21, tentatively through age 30

Data Source: National Education Longitudinal Study of 1988 (NELS: 88) (https://nces.ed.gov/surveys/nels88/)

Brief Description: The focus is on trend data about critical transitions experienced by students as they leave middle or junior high school, and progress through high school and into postsecondary institutions or the work force.

Examination Components: NELS: 88 features include: 1) Nationally representative, longitudinal study of 8th graders in 1998; 2) sample of students followed throughout secondary and postsecondary years; 3) Surveys of students reporting on school, work, home experiences, educational resources and support, the role in education of parents and peers, neighborhood characteristics, educational and occupational aspirations, and other student perceptions. Additional topics included self-reports on smoking, alcohol and drug use and extracurricular activities; 4) student assessments in reading, social studies, mathematics, and science (8th, 10th, and 12th grades); 5) Students' teachers, parents, and school administrators were also surveyed; and 6) high school and postsecondary transcripts data available for research on course taking and grades.

Table 245. National Education Longitudinal Study of 1988 (NELS: 88)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
The U.S. eighth grade class of 1997-98, the sophomore class of 1989-90, and the senior class of 1991-92 as they progressed through high school and until 2000	8th grade through 2000 (eight years post-high school graduation)	American Indian or Alaska Native, Asian, Black or African American, Hispanic, Native Hawaiian or Other Pacific Islander, and White	Socioeconomic status composite made up of: Household income, parents' education level, parents' occupation	Region. Census tract and zip codes for schools are available. The sample is not representative of students in particular cities, counties, or states.	1988, 1990, 1992, 1994, and 2000	The U.S. eighth grade class of 1997-98, the sophomore class of 1989-90, and the senior class of 1991-92 as they progressed through high school and until 2000	8th grade through 2000 (eight years post-high school graduation)

Data Source: School Survey on Crime and Safety (SSOCS) (https://nces.ed.gov/surveys/ssocs/)

Brief Description: SSOCS is the primary source of school-level data on crime and safety for the U.S. Department of Education, NCES. The SSOCS is a nationally representative cross-sectional survey of about 3,500 public elementary and secondary schools.

Examination Components: SSOCS includes the following topics: school practices and programs, parent and community involvement at school, school security, school mental health services, staff training and practices, limitations on crime prevention, frequency of crime and violence at school, number of incidents, disciplinary problems and actions, and school characteristics.

Table 246. School Survey on Crime and Safety (SSOCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
K-12 schools	K-12 principals	American Indian/Alaska Native, Asian, Black, Hispanic, Pacific Islander, and White	Free and reduced-price lunch from Common Core of Data	National estimates; broken down by Locale	2000, 2004, 2006, 2008, 2010, 2016	Restricted Use and Public Use	10th grade or 12th grade through 25-26

Data Source: School Crime Supplement (SCS) to the National Crime Victimization Survey (NCVS) (https://nces.ed.gov/programs/crime/surveys.asp)

Brief Description: Created as a supplement to NCVS and co-designed by NCES and BJS, the SCS survey collects information about victimization, crime, and safety at school. The SCS is a national survey of approximately 6,500 students ages 12 through 18 in U.S. public and private elementary, middle, and high schools. The SCS was conducted in 1989, 1995, 1999, 2001, 2003, 2005, 2007, 2009, 2011, 2013, and 2015.

Examination Components: SCS includes the following topics: student involvement in extracurricular activities, school security measures, fighting, bullying, hate behaviors, fear and avoidance behaviors, gun and weapon carrying, presence of gangs, and student characteristics.

Table 247. School Crime Supplement (SCS) to the National Crime Victimization Survey (NCVS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Household survey of students	Ages 12-18 years	White, Black, Hispanic, Asian, All other races	Household income	National estimates; broken down by Locale and Region	1989, 1995, 1999, 2001, 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, and 2019	Household survey of students ages 12-18	12-18

Data Source: Civil Rights Data Collection (CRDC) (https://ocrdata.ed.gov/)

Brief Description: The CRDC collects data on leading civil rights indicators related to access and barriers to educational opportunity at the early childhood through grade 12 levels. The CRDC is also a longstanding and critical aspect of the overall enforcement and monitoring strategy used by the Office for Civil Rights (OCR) to ensure that recipients of the Department's federal financial assistance do not discriminate based on race, color, national origin, sex, and disability. OCR relies on CRDC data it receives from public school districts as it investigates complaints alleging discrimination, determines whether the federal civil rights laws it enforces have been violated, initiates proactive compliance reviews to focus on particularly acute or nationwide civil rights compliance problems, and provides policy guidance and technical assistance to educational institutions, parents, students, and others. In addition, the CRDC is a valuable resource for other Department offices and federal agencies, policymakers and researchers, educators and school officials, parents and students, and the public who seek data on student equity and opportunity.

Examination Components: CRDC contains multiple topics related to health, including: Students absent 15 or more school days, number of incidents of violent and serious crimes, number of instances of corporal punishment for students preschool through grade 12, number of full-time employees for psychologists, social workers, nurses, security guards, and sworn law enforcement officers.

Table 248. Civil Rights Data Collection (CRDC)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Early childhood – grade 12	Early childhood – grade 12	American Indian/Alaska Native, Asian, Black, Hispanic, Pacific Islander, and White	Free and Reduced-price Lunch (FRPL)	School-level	Biennial (i.e., every other year)	Public use data available on website	Website allows for customizable "Special Reports" (e.g., English Learner report, Discipline report, Educational Equity report)

Data Source: The Program for the International Assessment of Adult Competencies (PIAAC) (https://nces.ed.gov/surveys/piaac/)

Brief Description: PIAAC is a cyclical, large-scale study that was developed under the auspices of the Organization for Economic Cooperation and Development (OECD). Adults were surveyed in 24 participating countries in 2012 and 9 additional countries in 2014. The goal of PIAAC is to assess and compare the basic skills and the broad range of competencies of adults around the world. The assessment focuses on cognitive and workplace skills needed for successful participation in 21st-century society and the global economy. Specifically, PIAAC measures relationships between individuals' educational background, workplace experiences and skills, occupational attainment, use of information and communications technology, and cognitive skills in the areas of literacy, numeracy, and problem solving. Note: No other country uses the race/ethnicity classification used by the United States.

Examination Components: PIAAC contains multiple topics related to health that are collected from United States respondents. This includes information about diet, exercise, and disease prevention.

Table 249. The Program for the International Assessment of Adult Competencies (PIAAC)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Non-institutionalized adults residing in each country, irrespective of nationality, citizenship, or language status	U.S. Sample: 16-74 years old; International sample: 16-65 years old	Hispanic; White; Black; Asian/Pacific Islander (U.S. only variables)	Parents' highest level of education attainment; Number of books in the home	Parents' highest level of education attainment; Number of books in the home	2012, 2014, & 2017	Public use microdata files are available on the website. Data in PIAAC Data Explorer (IDE) can be analyzed without needing statistical software	"First Look" released March 2016. Interactive Data Portal allows for generation of selected statistics

Data Source: Beginning Postsecondary Students (BPS) (https://nces.ed.gov/surveys/bps/)

Brief Description: Each cycle of the Beginning Postsecondary Students Longitudinal Study (BPS) follows a cohort of students who are enrolled in their first year of postsecondary education. The study collects data on student persistence in, and completion of, postsecondary education programs, their transition to employment, demographic characteristics, and changes over time in their goals, marital status, income, and debt, among other indicators. BPS tracks students' paths through postsecondary education and helps answer questions of policy interest, such as why students leave school, how financial aid influences persistence and completion, and what percentages of students' complete various degree programs.

Examination Components: BPS contains topics related to health. For example, respondents are asked to rate their physical health, mental health, and are also asked about the amount of missed school/work in the past 30 days due to a physical/mental health concern.

Table 250. Beginning Postsecondary Students (BPS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All first-time BPS (i.e., students with no prior postsecondary education at the time of the base year of the study) at all title IV postsecondary institutions in the United States (including 4-year, 2-year, and less-than-2-year institutions; and public, private non-profit, and private for-profit institutions). This population includes students seeking degrees and certificates lower than a bachelor's degree	This population includes students who did not immediately enroll in postsecondary classes after high school, so they can be of any age. In the base year of the most recent BPS (BPS:12/17) the sample had an average age of 21, with a minimum of 15, a maximum of 75, and a standard deviation of 6	White, Black or African American, Hispanic or Latino, Asian, American Indian or Alaska Native, Native Hawaiian/other Pacific Islander, More than one race	Adjusted Gross Income (AGI), income, parents' income, Income Group, Income percent of poverty level, spouse's income, Total income	Nationally representative estimates	There have been 4 BPS collections to date, each with two follow-up collections: 1990/1992/1994, 1996/1998/2001, 2004/2006/2009, 2012/2014/2017	Restricted use available with a license. Public use available for analysis through an online tool (Datalab and Powerstats)	First Look reports and Web Tables are released with all data files

Data Source: The National Postsecondary Student Aid Student (NPSAS) (https://nces.ed.gov/surveys/npsas/)

Brief Description: The purpose of NPSAS is to compile a comprehensive research dataset, based on student-level records, on financial aid provided by the federal government, the states, postsecondary institutions, employers, and private agencies, along with student demographic and enrollment data. NPSAS is the primary source of information used by the federal government (and others, such as researchers and higher education associations) to analyze student financial aid and to inform public policy on such programs as the Pell grants and Direct/Stafford loans.

Examination Components: NPSAS asks multiple questions related to disabilities including: *Are you deaf or do you have serious difficulty hearing? Are you blind or do you have serious difficulty seeing even when wearing glasses? Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (When answering consider conditions including, but not limited to, a serious learning disability, depression, ADD, or ADHD). Do you have serious difficulty walking or climbing stairs?* NPSAS asks questions about other types of impairments too.

Table 251. The National Postsecondary Student Aid Student (NPSAS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All undergraduate and graduate students enrolled in Title IV postsecondary institutions in the United States (including 4-year, 2-year, and less-than-2-year institutions; and public, private non-profit, and private for-profit institutions)	This population includes undergraduate and graduate students of all ages who are enrolled in postsecondary education institutions in a given academic year	White, Black or African American, Hispanic or Latino, Asian, American Indian or Alaska Native, Native Hawaiian/other Pacific Islander, More than one race	AGI, income, parents' income, Income Group, Income percent of poverty level, spouse's income, Total income, Parent's highest education	National. However, implicit stratification was done at the Region level to approximate proportional representation of institutions at the regional level	Every three to four years: 1987, 1990, 1993, 1996, 2000, 2004, 2008, 2012, and 2016	Restricted use available with a license. Public use available for analysis through an online tool (QuickStats, Powerstats, and TrendStats)	First Look reports and Web Tables are released with all data files. In addition, several Statistics in Brief reports are repeated for each cycle

Data Source: Baccalaureate and Beyond Longitudinal Study (B&B) (https://nces.ed.gov/surveys/b&b/about.asp)

Brief Description: The Baccalaureate and Beyond Longitudinal Study (B&B) examines students' education and work experiences after they complete a bachelor's degree, with a special emphasis on the experiences of new elementary and secondary teachers. Following several cohorts of students over time, B&B looks at bachelor's degree recipients' workforce participation, income and debt repayment, and entry into and persistence through graduate school programs, among other indicators. It addresses several issues specifically related to teaching, including teacher preparation, entry into and persistence in the profession, and teacher career paths. B&B also gathers extensive information on bachelor's degree recipients' undergraduate experience, demographic backgrounds, expectations regarding graduate study and work, and participation in community service.

Examination Components: B&B asks multiple questions relating to disabilities, such as: mobility impairments, motor impairments, reported disabilities in disabilities within a given year and nature of that disability. In a list of reasons respondents left an employer, B&B includes the option of "health reasons."

Table 252. Baccalaureate and Beyond Longitudinal Study (B&B)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All graduating seniors enrolled in Title IV postsecondary institutions in the United States (including 4-year, 2-year, and less-than-2-year institutions; and public, private non-profit, and private for-profit institutions)	This population includes undergraduate and graduate students of all ages who have graduated from postsecondary education institutions in a given academic year. In the base year of the most recent B&B (BPS:08/12) the sample had an average age of 25, with a minimum of 18, a maximum of 73, and a standard deviation of 7	White, Black or African American, Hispanic or Latino, Asian, American Indian or Alaska Native, Hawaiian/other Pacific Islander, Other, More than one race	AGI, income, parents' income, Income Group, Income percent of poverty level, spouse's income, Total income, Parent's highest education	Nationally representative estimates	There have been three B&B collections to date: 1993/1994/1997/2003, 2000/2001, 2008/2009/2012/2018	Restricted use available with a license. Public use available for analysis through an online tool (Datalab and Powerstats)	First look and Web tables are released with each datafile. Statistics in Brief reports

U.S. DEPARTMENT OF LABOR

U.S. Bureau of Labor Statistics

Data Source: Census of Fatal Occupational Injures (CFOI) (https://www.bls.gov/iif/oshcfoi1.htm)

Brief Description: The CFOI, collected by the Bureau of Labor Statistics (BLS) as part of the Injuries, Illnesses, and Fatal injuries (IIF) program (http://www.bls.gov/iif/), is the primary source of occupational fatality statistics for the United States. CFOI is a census that publishes a complete annual count (and select rates) of work-related fatal injuries and descriptive data on their case circumstances, including details on the incident, industry, geography, occupation, demographics, and other Census of Fatal Occupational Injures (CFOI) characteristics.

Examination Components: The CFOI is not a survey, but a census of collected data on workplace fatal injuries; the CFOI program uses a variety of public and private data sources to identify, verify, and describe fatal work injuries. Using multiple sources helps ensure counts are as complete and accurate as possible. The CFOI includes data for all fatal work injuries, even those that may be outside the scope of other agencies or regulatory coverage (see https://www.bls.gov/iif/cfoiscope.htm for more on scope). For more information on methodology see https://www.bls.gov/opub/hom/cfoi/home.htm. Aggregate data can be examined using online database tools found here: https://www.bls.gov/iif/data.htm. Confidential microdata is also available for analysis without personal identifiers (name, company, SSN) with an approved agreement (see below). Uses for the CFOI data include: Media organization interest in fatal injuries in news reporting; Preventing fatal injuries through safer work practices in safety management and job safety training; Understanding the circumstances surrounding work-related fatal injuries, such as workplace homicides; and Investigating vulnerable populations and demographics.

Table 253. Census of Fatal Occupational Injures (CFOI)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Workers in the United States and U.S. territories	All ages	Hispanic or Latino Ethnicity. White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Pacific Islander, Multiple races, Other races or not reported	Demographics (age, race or ethnic origin, gender), Occupation, Employee Status, Length of Service*, Size of Establishment, Birthplace (starting with 2001). Starting with 2011: Union Status*, Contractor status, Drug/Alcohol Use*. Starting in 2016: Educational Attainment*, Veteran Status*, Contingent/Alternative Worker* *Only available through the onsite or Federal Statistical Research Data Centers (FSDRCs) research file	National, state, MSA (starting in 1999)	1992 – present	Aggregate tables available for public use on CFOI homepage: https://www.bls.gov/iif/oshcfoi1.htm and database tools for custom queries: https://www.bls.gov/iif/data.htm Microdata research file upon research proposal approval: Offsite (masked data) and Onsite or FSDRCs (all data): https://www.bls.gov/rda/eligibility-and-access-modes.htm and https://www.bls.gov/iif/cfoi_offsite.htm	Annual Release, supplemented by various tables, charts, fact sheets, articles, etc.: https://www.bls.gov/iif/ Rates: https://www.bls.gov/iif/oshcfoi1.htm State Tables: https://www.bls.gov/iif/oshstate.htm

Data Source: Survey of Occupational Injuries and Illnesses (SOII) (https://www.bls.gov/iif/soii-data.htm)

Brief Description: SOII, collected by the BLS as part of the IIF program (https://www.bls.gov/iif/), is the primary source of non-fatal occupational injury and illness statistics for the United States. SOII is an establishment-based survey used to estimate incidence rates and counts of non-fatal workplace injuries and illnesses by industry and type of case: total recordable cases (TRC); days away from work; days of job transfer or restriction; or other recordable cases (ORC). Estimates of detailed case circumstances (event or exposure, source of injury or illness, such as machinery or tools, nature or type of injury or illness, part of body) and worker demographics (occupation, race, age, gender, etc.) are available for cases that involved one or more days away from work and, for select years and industries, for cases that required days of job transfer or restriction.

Examination Components: The SOII is a federal/state program in which employers' reports are collected annually from approximately 200,000 private industry and public sector (state and local government) establishments and processed by state agencies in cooperation with the BLS. For more information on methodology see https://www.bls.gov/opub/hom/soii/home.htm. Aggregate data can be examined using online database tools found here: https://www.bls.gov/iif/data.htm. Confidential microdata is also available for analysis without personal identifiers (name, company, SSN) with an approved agreement (see below).

Uses for the industry-level statistics include:

- The Occupational Safety and Health Administration (OSHA) uses SOII to measure the effectiveness of its industry-level enforcement and outreach programs in reducing work-related injuries and illnesses;
- Companies compare their rates to those of their industry to benchmark their worker safety and health performance;
- Firms applying for government contracts submit their injury rates relative to industry estimates;
- State-level policy makers use survey estimates to assess the safety and health of workers in their state and compare with other states doing similar types of work;
- OSHA and safety analysts can evaluate the efficacy of existing safety standards and policies and the potential impact of policy changes;
- Employer safety managers and employee union representatives use case circumstances to learn about the circumstances surrounding the incidents to explore potential ways to mitigate workplace hazards;
- Academic and insurance researchers use SOII data to estimate the costs of specific work-related injuries and illnesses;
- Industrial and safety engineers utilize data to develop new safety products to prevent workplace injuries and illnesses.

Table 254. Survey of Occupational Injuries and Illnesses (SOII)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Workers in the United States and U.S. territories	All ages	Hispanic or Latino; White, Black or African American; American Indian or Alaskan Native; Asian, Native Hawaiian or Pacific Islander; Multiple races; Other races or not reported	Demographics (age, race or ethnic origin, gender); Size of Establishment; Occupation; Length of Service	National, state	Industry-level, 1972 – present Case circumstances and worker demographics, 1992-present	Aggregate tables available for public use at: https://www.bls.gov/iif and database tools for custom queries: https://www.bls.gov/iif/data.htm Microdata research file with approved research proposal onsite or Federal Statistical Research Data Centers (FSRDCs) (all data): https://www.bls.gov/rda/eligibility-and-access-modes.htm	Annual release, supplemented by various fact sheets, articles, etc.: https://www.bls.gov/iif/ State Tables: https://www.bls.gov/iif/oshstate.htm

Data Source: National Compensation Survey (NCS) (https://www.bls.gov/ncs/)

Brief Description: The National Compensation Survey (NCS) is an establishment-based survey that provides comprehensive measures of (1) employer costs for employee compensation (wages and salaries as well as benefits), (2) compensation trends, and (3) the incidence of employer-sponsored benefits (including holidays and vacations, sick leave, health and life insurance, and retirement plans) among workers collected by BLS. The NCS also publishes data on provisions of selected employer-sponsored benefit plans.

Examination Components: The NCS produces indexes measuring change over time in labor costs through the Employment Cost Index (ECI) and the level of average costs per hour worked through the Employer Costs for Employee Compensation (ECEC). The NCS publishes data on the incidence of employer-provided benefits and on the key provisions (terms) of employee benefit plans, for civilian workers (as defined by the NCS), workers in private industry, and state and local government workers. The NCS publishes detailed provisions of coverage in the two major benefit areas of health insurance and retirement plans. Health data include medical plan provisions, such as deductibles, coinsurance, and out-of-pocket maximums, as well as details of dental, vision, and prescription drug benefits. Provisions of defined benefit and defined contribution retirement plans include eligibility requirements, vesting, and benefit amount formulas. These data are obtained from Health and Retirement Summary Plan Descriptions (SPDs), which are employer required documents that tell participants what the plans provide and how they operate. Uses for NCS Estimates of the Incidence and (Key and Detailed) Provisions of Benefits include: Planning and improving company benefits; Lowering turnover rates; Aiding collective bargaining negotiations; Understanding health benefits data; Assessing and formulating public policy. For more information on methodology see https://www.bls.gov/opub/hom/ncs/home.htm.

Table 255. National Compensation Survey (NCS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Workers in the U.S.	N/A	N/A	Occupation, Compensation, Benefits	National, census region	Varies	"Public Tables and Custom Queries are available from: https://www.bls.gov/ect/ (employment cost) and www.bls.gov/ebs (employees benefits)	Quarterly, Annually: ECI news release (https://www.bls.gov/news.release/pdf/eci.pdf) ECEC news release (https://www.bls.gov/news.release/pdf/ecec.pdf); Employee Benefits in the United States news release (https://www.bls.gov/news.release/pdf/ebs2.pdf); And, Health and Retirement Plan Provisions in the United States (https://www.bls.gov/ncs/ebs/detailedprovisions/home.htm)

Data Source: Occupational Requirements Survey (ORS) (https://www.bls.gov/opub/hom/ors/home.htm)

Brief Description: ORS is an establishment-based survey conducted by BLS. The ORS provides comprehensive data on specific work-related requirements. BLS publishes information on physical demands (e.g., standing, lifting, climbing), environmental conditions (e.g., extreme temperatures, heavy vibrations, hazardous contaminants), education, training, and experience, as well as mental and cognitive requirements (e.g., decision making, adaptability, contacts) for detailed occupations in the U.S. economy.

Examination Components: The ORS sample frame includes establishments in the 50 states and the District of Columbia in the private sector and state and local governments. To maximize the amount of publishable information, the BLS is combined data from three annual ORS samples to produce the 2018 estimates from roughly 26,500 sampled establishments. Beginning with the fourth year of collection, the ORS is combining data across five annual sample groups with roughly 10,000 establishments each. Uses for the ORS data include: assisting the Social Security Administration in its disability adjudication process; new research opportunities for academia, government, and private sector; assessing the nature of work; benchmarking job descriptions or developing targeted recruiting plans; helping insurance companies assess risk management; assisting temporary help firms properly match an employee to job openings. For more information on methodology see www.bls.gov/opub/hom/ors/home.htm.

Table 256. Occupational Requirements Survey (ORS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Workers in the U.S.	N/A	N/A	Occupation	National	Starting in 2016 – present	"Public Group Profiles: www.bls.gov/ncs/ors/orsprofiles.pdf Database: https://www.bls.gov/ncs/ors/data.htm	Annual Release: www.bls.gov/news.release/pdf/ors.pdf

Data Source: American Time Use Survey (ATUS) (https://www.bls.gov/tus)

Brief Description: ATUS measures the amount of time people spend doing various activities, such as paid work, childcare, volunteering, and in sports and leisure. The ATUS is sponsored by BLS and conducted by the U.S. Census Bureau.

Examination Components: ATUS provides nationally representative estimates of how, where, and with whom Americans spend their time, and is the only federal survey providing data on the full range of non-market activities, from childcare to volunteering. ATUS data files are used by researchers to study a broad range of issues; the data files include information collected from over 190,000 interviews conducted from 2003 to 2017. ATUS data files can be linked to data files from CPS. This expands the context in which time use data can be analyzed and saves taxpayer money because fewer questions must be asked in the ATUS interview. For more information see the summary fact sheet at https://www.bls.gov/tus/atussummary.pdf and the methodology at https://www.bls.gov/opub/hom/atus/home.htm.

Table 257. American Time Use Survey (ATUS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. civilian non-institutionalized population	15 and over	Black or African American; White, Asian, Hispanic or Latino (of any race)	Labor force status, earnings, occupation, educational attainment, sex, marital status, household composition, Eating and Health Module (2006-2008 and 2014-2016), Well-being Module (2010, 2012, 2013)	National (public), census region, census division	2003-2017	Public Tables: https://www.bls.gov/tus/tables.htm Public Database: https://www.bls.gov/tus/database.htm Public Use Files: https://www.bls.gov/tus/data.htm	Annual News Release: https://www.bls.gov/news.release/pdf/atus.pdf Biennial Unpaid Eldercare in the United States News Release https://www.bls.gov/news.release/pdf/elcare.pdf

Data Source: National Longitudinal Surveys (NLS) (https://www.bls.gov/nls/)

Brief Description: NLS, sponsored by the BLS, are designed to gather information at multiple points in time on the labor market activities and other significant life events of several groups of men and women. For more than five decades, NLS data have served as an important tool for economists, sociologists, and other researchers.

Examination Components: The NLS surveys are based upon stratified multistage samples, with oversamples of Blacks and Hispanics in the ongoing NLSY79 and NLSY97 surveys. NLS data are important tools for economists, sociologists, psychologists, and other researchers in the study of labor supply, earnings and income distribution, job search and separation, training, and other human capital investments. In addition, these data are used to study the effect of government policies and programs on labor market behaviors. Methodology can be found at https://www.bls.gov/opub/hom/pdf/nls-20030904.pdf and https://www.nlsinfo.org/.

Table 258. National Longitudinal Surveys (NLS)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
United States Population	Information available	Information available	Employment, sex, education, training, marriage, cohabitation, health, children, income, assets, expectations, cognitive test scores, government program participation, and much more	National (public), State, County, MSA, zip code/census tract (all restricted)	Varies – 1960s – present	Public Tables: https://www.bls.gov/nls/tables.htm https://www.bls.gov/nls/news.htm Public Use Data: https://www.nlsinfo.org/investigator/pages/login.jsp Confidential Application for Geocode Data: https://www.bls.gov/nls/geocodeapp.htm Information about restricted access zip code and census tract files: https://www.bls.gov/nls/nlsfaqs.htm	News Release: https://www.bls.gov/nls/news.htm

U.S. DEPARTMENT OF TRANSPORTATION

Data Source: National Highway Traffic Safety Administration (NHTSA) (https://www.nhtsa.gov/)

Brief Description: NHTSA was established by the Highway Safety Act of 1970 and is dedicated to achieving the highest standards of excellence in motor vehicle and highway safety. It works daily to help prevent crashes and their attendant costs, both human and financial.

Examination Components: motor vehicle traffic crashes, traffic crashes fatalities, Vehicle occupants, motorcyclists, other national statistics. (miles traveled, resident population, registered vehicles, licensed drivers), national rates for fatalities.

Table 259. National Highway Traffic Safety Administration (NHTSA)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
All	Sex, race and ethnicity. Uses the national Center for Health Statistics Ancestry Codes (Ancestry/ ethnicity description)	NHTSA has 10 Regional offices that work on the agency's mission to save lives, prevent injuries, and reduce traffic-related healthcare and other economic costs. Each Regional office provides numerous services to its states, as well as other public and private sector customers. These services include, but are not limited to, technical assistance, promoting legislation, administering the agency's grant fund programs, assisting in coalition building and delivering training. For information on research conducted by NHTSA's refer to https://www.nhtsa.gov/research-data	Starting in 1975 to present	Available at http://www.nhtsa.gov/FARS	Program highlights (fatalities statistics and survey of state laws) available at http://www.safercar.gov/Vehicle+Shoppers/Passenger+Van+Safety or Recent Research & Data at http://www.nhtsa.gov/.	To access the data from the Fatality Analysis Reporting System (FARS) refer to https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars Downloading raw data at ftp://ftp.nhtsa.dot.gov/fars/	Publications and customized data request are available at http://www-nrd.nhtsa.dot.gov/CMSWeb/index.aspx or at http://www-nrd.nhtsa.dot.gov/CMSWeb/listpublications.aspx?Id=I&ShowBy=DocType

U.S. DEPARTMENT OF VETERANS AFFAIRS

Data Source: Hepatitis C Virus – Advanced Liver Disease Disparities Data (HCV-ALD) (http://catalog.data.gov/dataset/hepatitis-c-advanced-liver-disease-disparities-dashboard)

Brief Description: The Office of Health Equity (OHE) created the Hepatitis C-Advanced Liver Disease (HCV-ALD) dashboard to raise awareness of potential disparities among vulnerable Veterans for this life-threatening condition. The purpose of the HCV-ALD Dashboard is promote equitable diagnosis and treatment of underserved Veterans with hepatitis C and advanced liver disease. The Hepatitis C-ALD Dashboard utilizes a set of criteria – age, gender, geography, service era, race/ethnicity – to characterize Veteran groups with ALD due to hepatitis C who may require targeted intervention to improve their health. The dashboard advances the vision for quality care and improved access to care as identified in the VHA Blueprint for Excellence.

Examination Components: Administrative data for Veterans diagnosed with HCV.

Table 260. Hepatitis C Virus – Advanced Liver Disease Disparities Data (HCV-ALD)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Veterans	Information available by gender and age	American Indian and Alaska; Asian; Black; Hispanic or Latino; Native Hawaiian and Pacific Islander; Multiple; Unknown	N/A	VA Facility VA Integrated Service Network State	2015	Available	N/A

Data Source: National Veteran Health Equity Report – FY13 (https://catalog.data.gov/dataset/national-veteran-health-equity-report-fy13)

Brief Description: The National Veteran Health Equity Report details patterns and provides comparative rates of health conditions for vulnerable Veteran groups. Specifically, this report is designed to provide basic comparative information on the sociodemographic, utilization patterns and rates of diagnosed health conditions among the groups over which the VHA OHE has responsibility with respect to monitoring, evaluating and acting on identified disparities in access, use, care, quality and outcomes. The report allows VA, Veterans, and stakeholders to monitor the care vulnerable Veterans receive and set goals for improving their care.

Examination Components: Administrative data for Veterans.

Table 261. National Veteran Health Equity Report – FY13

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Administrative data for Veterans	Information available by gender and age	American Indian and Alaska; Asian; Black; Hispanic or Latino; Native Hawaiian and Pacific Islander; Multiple; Unknown	N/A	N/A	2013	Available	N/A

INTERAGENCY DATASETS

Data Source: Federal Interagency Forum on Aging-Related Statistics (https://agingstats.gov/)

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 (National Institute on Aging, National Center for Health Statistics and Census Bureau), the organizing members of the Forum now include senior officials from the Administration for Community Living (formerly the Administration on Aging), Agency for Healthcare Research and Quality, Bureau of Labor Statistics, Centers for Medicare and Medicaid Services, Consumer Product Safety Commission, Department of Housing and Urban Development, 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 the Department of Health and Human Services (HHS), Social Security Administration, and the Substance Abuse and Mental Health Services Administration. The initiative produces a variety of aging-related products, including a comprehensive report, Older Americans 2016: Key Indicators of Well-Being (https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf). The report provides the data on the 41 key indicators selected by the Forum to portray aspects of the lives of older Americans and their families. It is divided into six subject areas: population, economics, health status, health risks and behaviors, healthcare, and environment.

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.

Table 262. Federal Interagency Forum on Aging-Related Statistics

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Downloadable Excel tables and figures are available for the report. In addition, the website hosts information on Data resources representing ongoing, federally sponsored surveys relevant to the aging. https://agingstats.gov/fed-data-resources.html. Other resources on the site include infographics, a glossary and access to other aging-related reports	Available every four years (2000, 2004, 2008, 2010, 2012, 2016) at: https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf

Data Source: Federal Interagency Forum on Child and Family Statistics (http://www.childstats.gov/).

Brief Description: The Federal Interagency Forum on Child and Family Statistics (Forum) was chartered in 1997 by the authority of Executive Order No. 13045. The Forum fosters collaboration among 23 federal agencies that (1) produce and/or use statistical data on children and (2) seek to improve federal data on those children. Each year, the Forum publishes a report on the well-being of children. This series of reports, entitled America's Children, provides accessible compilations of well-being indicators drawn from the most reliable federal statistics. A goal of the series is to make federal data on children available in a non-technical, easy-to-use format to stimulate discussion among data providers, policymakers, and the public. The Forum alternates publishing a detailed report, America's Children: Key National Indicators of Well-Being, with a shorter report, America's Children in Brief. In some years, America's Children in Brief highlights selected indicators while other editions focus on a particular topic and measures of child well-being not featured in the detailed report. America's Children in Brief, Federal Interagency Forum on Child and Family Statistics 2018 describes selected characteristics of children whose well-being may be at highest risk.

Examination Components: The Forum has identified 41 key national indicators collected by federal agencies that describe the well-being of children. The indicators are updated annually on the Forum's website (https://childstats.gov), pending data availability. These indicators span seven domains: Family and Social Environment, Economic Circumstances, Healthcare, Physical Environment and Safety, Behavior, Education, and Health. In addition, they must meet the following criteria:

- Easy to understand by broad audiences
- Objectively based on reliable data with substantive research connecting them to child well-being
- Balanced, so that no single area of children's lives dominates the report
- Measured regularly, so that they can be updated and show trends over time
- Representative of large segments of the population, rather than one particular group

In compiling these 41 indicators, the Forum carefully examines the available data while also seeking input from the federal policymaking community, foundations, academic researchers, and state and local children's service providers. *America's Children in Brief, 2018* concludes with a summary table displaying the most recent data for all 41 key national indicators in America's Children at a Glance.

Table 263. Federal Interagency Forum on Child and Family Statistics

Target Population	Age	Race & Ethnicity	Socioeconomic 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, healthcare, 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: http://www.childstats.gov/datasources/datatools.asp Another relevant tool provides links to databases comparing the well-being of children in the U.S. with those in other countries: http://www.childstats.gov/datasources/intnllinks.asp	Available upon request at: http://childstats.gov/pubs

Data Source: Health, United States (https://www.cdc.gov/nchs/hus/index.htm)

Brief Description: *Health, United States* is a legislatively mandated annual report on the health status of the country, submitted by the Secretary of the U.S. Department of Health and Human Services to the President and the Congress of the United States. Since 1974, the report has presented an overview of national health trends organized around four subject areas: health status and determinants, utilization of health resources, healthcare resources, and healthcare expenditures and payers. An important criterion used in selecting indicators is the availability of comparable national data over a period of several years. While the number of figures and tables varies, the 2017 report contained over 100 indicators in 30 figures and 114 long-term trend tables. All sections of the report are available to users for download; all data are also available as spreadsheets (in Microsoft Excel format) for further analysis and graphing by readers. The annual *Health, United States* contents page (currently https://www.cdc.gov/nchs/hus/contents2017.htm) includes a population drop-down menu highlighting tables and charts featuring specific populations of interest so that disparities may be examined.

Examination Components: *Health, United States* brings together trends in statistics from dozens of government data sources, including vital statistics, nationally representative survey data, and administrative data sources, as well as private and global data sources. A complete listing and description of data sources is available in the *Health, United States* Appendix I: Data Sources (https://www.cdc.gov/nchs/hus/appendix.htm).

Table 264. Health, United States

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
U.S. population	May differ by indicator 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)	Available, may differ by indicator	Differs by indicator; some indicators available by education, functional limitation, health insurance, and poverty	Varies by indicator; National with limited state-level data. Data are collected at an individual or organization level but are only presented at an aggregate level	Varies; figures use data for the decade through the most recent data available from the data source Trend tables may contain annual or periodic data since 1997, 1988 or 1950	Available to the public. Individual spreadsheets available for download from the most recent report https://www.cdc.gov/nchs/hus/contents2017.htm	*Health, United States* is available annually at https://www.cdc.gov/nchs/hus/index.htm

Data Source: Healthy People (http://www.healthypeople.gov/)

Brief Description: Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time. Healthy People is managed by the Office of Disease Prevention and Health Promotion (ODPHP) at the HHS, with data and statistical support from the CDC's National Center for Health Statistics. Healthy People 2020 includes over 1,100 measurable objectives, spanning 42 topic areas and using about 176 different data sources. The Healthy People website (www.healthypeople.gov) includes a health disparities tool, highlighting data and charts for population-based data in Healthy People; and a health disparities widget, which allows featured health disparities content related to the Healthy People Leading Health Indicators to be shared on other websites.

Examination Components: Healthy People is a collaborative effort that involves support and guidance from the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives, the Federal Interagency Workgroup, Lead Federal Agencies, and the general public (through public comment).

Table 265. Healthy People

Target Population	Age	Race & Ethnicity	Socioeconomic 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)	Available, may differ by indicator	Differs by indicator; many population-based indicators include education, income, and health insurance status	Varies by indicator; can be national or state. Data are collected at an individual or organization level but are only presented at an aggregate level	Varies; generally, from roughly 2005-2008 through most recent data available from the data source	Available to the public. A drop-down list of data sources is available at https://www.healthypeople.gov/2020/data-search/	Healthy People data publications by NCHS are available at https://www.cdc.gov/nchs/healthy_people/publications.htm

Data Source: Tobacco Use Supplement to the Current Population Survey (TUS-CPS) (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 triennially, 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 - tusks)

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.

Table 266. Tobacco Use Supplement to the Current Population Survey (TUS-CPS)

Target Population	Age	Race & Ethnicity	Socioeconomic 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	Available at https://cancercontrol.cancer.gov/brp/tcrb/tus-cps/	Tables from select years available: http://appliedresearch.cancer.gov/studies/tus-cps/publications.html

Data Source: Social Security Administration Supplement to Survey of Income and Program Participation (SIPP SSA Supplement) (https://www.census.gov/programs-surveys/sipp/about/SSA-Supplement.html)

Brief Description: The U.S. Census Bureau conducted the Social Security Administration Supplement on Retirement, Pensions, and Related Content (SSA Supplement) on behalf of the SSA. The SSA Supplement is a separate survey from SIPP, even though the sample consists of households that completed 2014 Wave 1 SIPP interviews. Topics included in the SSA Supplement include work, adult, and child disabilities, personal retirement account contributions and withdrawals, participation in pension and retirement plans provided by an employer or business, marital history, and health status.

Examination Components: The SSA Supplement is a one-time survey conducted after Wave 1 of the 2014 SIPP panel, from September through November 2014. All interviews were conducted by centralized telephone – there was no personal visit component. The SSA Supplement data can be used independently or merged with the 2014 Wave 1 SIPP data.

Table 267. Social Security Administration Supplement to Survey of Income and Program Participation (SIPP SSA Supplement)

Target Population	Age	Race & Ethnicity	Socioeconomic Variables	Geographic Estimates (Lowest Geographic Unit)	Years of Data Collected	Available for Use	Periodic Reports
Civilian Non-Institutionalized	All age groups. No gender restriction.	Black; White; Asian; Other; Hispanic	Income; education; employment; marital status; program participation including (SNAP, WIC, TANF, General Assistance)	National	2014	Available at https://www.census.gov/programs-surveys/sipp/data/2014-panel/ssa.html	N/A

APPENDIX 1. GLOSSARY OF ACRONYMS

Table 268. Glossary

Acronym	Definition
AAD	Alcohol-attributable Deaths
AAF	Alcohol-attributable Fractions
AAP	American Academy of Pediatrics
ABC	Active Bacterial Core
ABLES	Adult Blood Lead Epidemiology & Surveillance
AC	Asthma Counselor
ACASI	Audio Computer-assisted Self-interview
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACS	American Community Survey
ACT	Activity Counseling Trial
ADDM	Autism and Developmental Disabilities Monitoring
ADL	Activities of Daily Living
AEDS	Alcohol Epidemiologic Data System
AETC	AIDS Education and Training Centers
AFCARS	Adoption and Foster Care Analysis and Reporting System
AGI	Adjusted Gross Income
AGID	Aging Integrated Databases
AHC	Accountable Health Communities
AHRF	Area Health Resource File
AHRQ	Agency for Healthcare Research and Quality
AIDD	Administration for Intellectual and Developmental Disabilities
AoA	Administration on Aging
API	Application Programming Interface
AQS	Air Quality System
ARDI	Alcohol-Related Disease Impact
ARF	Area Resource File
ARIC	Atherosclerosis Risk in Communities
ASD	Autism Spectrum Disorders

Acronym	Definition
ASL	Ambulatory Surgery Locations
ASPE	Assistant Secretary for Planning and Evaluation
ATTAINS	Assessment TMDL Tracking and Implementation System
ATUS	American Time Use Survey
AUR	Antimicrobial Use and Resistance
BJS	Bureau of Justice Statistics
BLL	Blood Lead Levels
BLS	Bureau of Labor Statistics
BMI	Body Mass Index
BOP	Bureau of Prisons
BP	Blood Pressure
BPS	Beginning Postsecondary Students
BRFSS	Behavioral Risk Factor Surveillance System
CAA	Care Area Assessments
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAPI	Computer-assisted Personal Interviewing
CARDIA	Coronary Artery Risk Development in Young Adults
CARF	Commission on Accreditation of Rehabilitation Facilities
CAUTI	Catheter-associated Urinary Tract Infections
CBDPP	Community-Based Dental Partnership Program
CBER	Center for Biologics Evaluation and Research
CBHSQ	Center for Behavioral Health Statistics and Quality
CC	Community Counts
CCD	Common Core of Data
CCDF	Child Care and Development Fund
CCW	Chronic Conditions Warehouse
CDC	Centers for Disease Control
CDE	Common Data Elements
CDER	Center for Drug Evaluation and Research
CDETF	Common Data Elements Task Force
CEFI	Cost Estimates of Foodborne Illness
CFOI	Census of Fatal Occupational Injures
CHD	Coronary Heart Disease

Acronym	Definition
CHIP	Children’s Health Insurance Program
CHS	Cardiovascular Health Study
CIHS	Center for Integrated Health Solutions
CLABSI	Central Line-associated Bloodstream Infections
CPES	Collaborative Psychiatric Epidemiology Surveys
CPM	Clinical Performance Measures
CPS	Current Population Survey
CRDC	Civil Rights Data Collection
CRE	Carbapenem-resistant Enterobacteriaceae
CSAT	Center for Substance Abuse Treatment
CSHCN	Children with Special Health Care Needs
CVD	Cardiovascular Disease
DASH	Data and Specimen Hub
DASIS	Drug and Alcohol Services Information System
DAWN	Drug Abuse Warning Network
DBDR	Division of Blood Diseases and Resources
DCVS	Division of Cardiovascular Sciences
DE	Data Element
DEA	Drug Enforcement Administration
DHDS	Disability and Health Data System
DHHS	Department of Health and Human Services
DHQP	Division of Healthcare Quality Promotion
DIS	Diagnostic Interview Schedule
DRP	Dental Reimbursement Program
DTaP	Diphtheria and Tetanus Toxoids and Acellular Pertussis
DTBE	Division of Tuberculosis Elimination
DTS	Drug Trials Snapshots
DUA	Data Use Agreement
ECA	Epidemiologic Catchment Area
ECEC	Employer Costs for Employee Compensation
ECHO	Enforcement & Compliance History Online
ECI	Employment Cost Index
ECLS	Early Childhood Longitudinal Study

Acronym	Definition
ECPP	Early Childhood Program Participation
ED	Emergency Department
EH	Eating & Health
EHDI	Early Hearing Detection and Intervention
EHM	Eating and Health Module
EHR	Electronic Health Records
EIP	Emerging Infections Program
EMAP	Environmental Monitoring and Assessment Program
EMR	Electronic Medical Records
EPA	Environmental Protection Agency
EPESE	Established Populations for Epidemiologic Studies of the Elderly
ESRD	End-stage Renal Disease
FAERS	FDA Adverse Event Reporting System
FARA	Food Access Research Atlas
FARS	Fatality Analysis Reporting System
FCBS	Flexible Consumer Behavior Survey
FDA	Food and Drug Administration
FFS	Fee-for-Service
FIHET	Federal Interagency Health Equity Team
FISP	Families Information Systems Project
FNS	Food and Nutrition Service
FoodAPS	Food Acquisition and Purchase Survey
FQHC	Federally Qualified Health Centers
FRS	Facility Registry System
FVC	Forced Vital Capacity
HA	Housing Agencies
HAI	Healthcare-associated Infections
HC	Household Component
HCAHPS	Hospital Consumer Assessment Providers and Systems
HCFA	Healthcare Financing Administration
HCUP	Healthcare Cost and Utilization Project
HCV	Housing Choice Vouchers
HCVP	Housing Choice Voucher Program

Acronym	Definition
HD	Huntington’s Disease
HEDIS	Healthcare Effectiveness Data and Information Set
HF	Heart Failure
HHP	Honolulu Heart Program
HHS	Health and Human Services
HINTS	Health Information National Trends Survey
HITECH	Health Information Technology for Economic and Clinical Health
HRQOL	Health-Related Quality of Life
HRR	Hospital Referral Region
HRS	Health and Retirement Study
HRSA	Health Resources and Services Administration
HSPIR	Head Start Program Information Report
HTC	Hemophilia Treatment Centers
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
IC	Insurance Component
ICATA	Inner-City Anti-IgE Therapy for Asthma
ICPSR	Inter-University Consortium for Political and Social Research
IDD	Intellectual and/or Developmental Disabilities
IHS	Indian Health Service
IIF	Injuries, Illnesses, and Fatal
IRIS	Integrated Risk Information System
ISF	Insufficient Number of Symptoms or Fatigue
IUR	Inhalation Unit Risk
KID	Kids' Inpatient Database
LBD	Lewy Body Dementia
LHS	Lung Health Study
LIHTC	Low-Income Housing Tax Credit
LRCPS	Lipid Research Clinics Prevalence Study
LSOA	Longitudinal Studies of Aging
MA	Medicare Advantage
MADDSP	Metropolitan Atlanta Developmental Disabilities Surveillance Program
MAO	Medicare Advantage Organization

Acronym	Definition
MCBS	Medicare Current Beneficiary Survey
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau
MCV	Measles-containing Vaccine
MDS	Minimum Data Set
MEPS	Medical Expenditure Panel Survey
MESA	Multi-Ethnic Study of Atherosclerosis
MHOS	Medicare Health Outcomes Survey
MI	Myocardial Infarction
MMD	Mapping Medicare Disparities
MMP	Medical Monitoring Project
MMR	Measles, Mumps, and Rubella
MMWR	Morbidity and Mortality Weekly Report
MPC	Medical Provider Component
MRFIT	Multiple Risk Factor Intervention Trial
MRI	Magnetic-resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MTF	Monitoring the Future
NACDA	National Archive of Computerized Data on Aging
NACHC	National Association of Community Health Centers
NACJD	National Archive of Criminal Justice Data
NACRHHS	National Advisory Committee on Rural Health and Human Services
NAEP	National Assessment of Educational Progress
NAHDAP	National Addiction & HIV Data Archive Program
NAMCS	National Ambulatory Medical Care Survey
NCANDS	National Child Abuse and Neglect Data System
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NCES	National Center for Education Statistics
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCICAS	National Cooperative Inner-City Asthma Study
NCS	National Comorbidity Survey

Acronym	Definition
NCVS	National Crime Victimization Survey
NDI	National Death Index
NDW	National Data Warehouse
NEDS	Nationwide Emergency Department Sample
NEHRS	National Electronic Health Records Survey
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NFR	National Facility Register
NGHS	NHLBI Growth and Health Study
NHAMCS	National Hospital Ambulatory Medical Care Survey
NHANES	National Health and Nutrition Examination Survey
NHBS	National HIV Behavioral Surveillance System
NHCS	National Hospital Care Survey
NHDR	National Healthcare Disparities Report
NHDS	National Hospital Discharge Survey
NHES	National Household Education Surveys
NHHAS	National Home Health Aide Survey
NHHCS	National Home and Hospice Care Survey
NHIS	National Health Interview Survey
NHLBI	National Heart, Lung and Blood Institute
NHQR	National Healthcare Quality Report
NHSN	National Healthcare Safety Network
NHTSA	National Highway Traffic Safety Administration
NIA	National Institute on Aging
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIAID	National Institute of Allergy and Infectious Diseases
NIBIB	National Institute of Biomedical Imaging and Bioengineering
NICHD	National Institute of Child Health and Human Development
NICHQ	National Institute for Children’s Health Quality
NIDA	National Institute on Drug Abuse
NIDDK	National Institute of Diabetes and Digestive and Kidney
NIES	National Indian Education Study
NIH	National Institutes of Health
NIMH	National Institute on Mental Health

Acronym	Definition
NINDS	National Institute of Neurological Disorders and Stroke
NIOSH	National Institute for Occupational Safety and Health
NIRS	National Information Reporting System
NIS	National Immunization Survey
NISVS	National Intimate Partner and Sexual Violence Survey
NLAAS	National Latino and Asian American Study
NLAES	National Longitudinal Alcohol Epidemiologic Survey
NLMS	National Longitudinal Mortality Study
NLS	National Longitudinal Surveys
NLTCS	National Long-Term Care Surveys
NNAS	National Nursing Assistant Survey
NNDSS	National Notifiable Diseases Surveillance System
NNHS	National Nursing Home Survey
NNYFS	NHANES National Youth Fitness Survey
NOMS	National Outcome Measures
NORS	National Outbreak Reporting System
NPCR	National Program of Cancer Registries
NPIRS	National Patient Information Reporting System
NPS	National Prisoner Statistics
NPSAS	National Postsecondary Student Aid Student
NQF	National Quality Forum
NRD	Nationwide Readmissions Database
NSAL	National Survey of American Life
NSAM	National Survey of Adolescent Males
NSAP	National Survey of Adoptive Parents
NSDUH	National Survey on Drug Use and Health
NSECH	National Survey of Early Childhood Health
NSFG	National Survey of Family Growth
NSLTCP	National Study of Long-Term Care Providers
NSPHC	National Survey of Prison Health Care
NSRCF	National Survey of Residential Care Facilities
NTIES	National Treatment Improvement Evaluation Study
NVDRS	National Violent Death Reporting System

Acronym	Definition
NVSS	National Vital Statistics System
NYTD	National Youth in Transition Database
NYTS	National Youth Tobacco Survey
OASIS	Outcome and Assessment Information Set
ODPHP	Office of Disease Prevention and Health Promotion
OECD	Organization for Economic Cooperation and Development
OHE	Office of Health Equity
OMB	Office of Management and Budget
OPD	Outpatient Departments
OPTN	Organ Procurement and Transplantation Network
ORC	Other Recordable Cases
ORS	Occupational Requirements Survey
OSF	Oral Slope Factor
OSHA	Occupational Safety and Health Administration
P&A	Protection and Advocacy
PA	Physician Assistants
PACE	Program of All-Inclusive Care for the Elderly
PCV	Pneumococcal Conjugate Vaccine
PD	Parkinson’s Disease
PHA	Public Housing Agencies
PIAAC	Program for the International Assessment of Adult Competencies
PM	Prescribed Medications
PMSS	Pregnancy Mortality Surveillance System
PRAMS	Pregnancy Risk Assessment Monitoring System
PRAPARE	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
PRHHP	Puerto Rico Heart Health Program
PSS	Private School Survey
PSU	Primary Sampling Units
PVD	Peripheral Vascular Disease
RAD	Restricted Access Database
RCA	Rapid Cycle Analysis
RCMAR	Resource Centers for Minority Aging Research

Acronym	Definition
RDC	Research Data Center
ResDAC	Research Data Assistance Center
RISP	Residential Information System Project
RSV	Respiratory Syncytial Virus
RWHAP	Ryan White HIV/AIDS Program
SABG	Substance Abuse Prevention and Treatment Block Grant
SAE	Small Area Estimation
SAMHSA	Substance Abuse and Mental Health Services Administration
SASD	Surgery and Services Databases
SCD	Sickle Cell Disease
SCDTP	Sickle Cell Disease Treatment Demonstration Program
SCS	School Crime Supplement
SDOH	Social Determinants of Health
SDU	Service Delivery Unit
SDWIS	Safe Drinking Water Information System
SEDD	State Emergency Department Databases
SEER	Surveillance, Epidemiology, and End Results
SENSOR	Sentinel Event Notification System for Occupational Risk
SHPPS	School Health Policies and Practices Study
SID	State Inpatient Databases
SIFCF	Survey of Inmates in Federal Correctional Facilities
SILJ	Survey of Inmates in Local Jails
SIPP	Survey of Income and Program Participation
SIR	Standardized Infection Ratio
SISCF	Survey of Inmates in State Correctional Facilities
SLRA	State Legislative and Regulatory Action
SNAP	Supplemental Nutrition Assistance Program
SOA	Supplement on Aging
SOII	Survey of Occupational Injuries and Illnesses
SPD	Summary Plan Descriptions
SPI	Survey of Prison Inmates
SRTR	Scientific Registry of Transplant Recipients
SSA	Social Security Administration

Acronym	Definition
SSI	Surgical Site Infections
SSOCS	School Survey on Crime and Safety
STATE	State Tobacco Activities Tracking and Evaluation
STDSS	Sexually Transmitted Diseases Surveillance System
STEM	Science, Technology, Engineering, and Math
TANF	Temporary Assistance for Needy Families
TDCRP	Treatment of Depression Collaborative Research Program
TEDS	Treatment Episode Data Set
TEL	Technology and Engineering Literacy
TIA	Transient Ischemic Attack
TIMS	Tuberculosis Information Management System
TMDL	Total Maximum Daily Loads
TRC	Total Recordable Cases
TRI	Toxic Release Inventory
TVIS	Title V Information System
UCEDD	University Centers for Excellence in Developmental Disabilities
UDC	Universal Data Collection
UDS	Uniform Data System
UFDS	Uniform Facility Data Set
UNOS	United Network of Organ Sharing
VA	Veterans Affairs
VAERS	Vaccine Adverse Event Reporting System
VSD	Vaccine Safety Datalink
WATERS	Watershed Assessment, Tracking & Environmental Results
WHO	World Health Organization
WONDER	Wide-ranging Online Data for Epidemiologic Research
YPLL	Years of Potential Life Lost
YRBSS	Youth Risk Behavior Surveillance System