

Potential Data Sources for Generating Baseline Data

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Outline

- Introduction
- Purpose of collecting baseline data
 - > Definition of baseline data
 - > Intervention group
 - > Type of baseline data
- Characteristics of baseline data
- Potential sources of baseline data
- Review of potential data sources

What is Baseline Data

- Collected before a program begins
- Expected outcome(s) of program
- Characteristics of people being served
- Example:
 - > % of infants born to women served by the program in the past year who were born prior to 37 weeks gestation

Sample Baseline Data (Hypothetical):

Preterm Births for Medicaid Beneficiaries in Beachville County

	2008-2009	2009-2010	2010-2011
% births < 37 weeks EGA: women < 20 years of age	18.7%	18.9%	17.9%
% births < 37 weeks EGA: women 20-29	15.6%	14.3%	15.0%
% births < 37 weeks EGA: women 30-39	16.9%	17.3%	16.2%
% births < 37 weeks EGA: women ≥ 40	20.4%	19.2%	20.2%

Purpose of Collecting Baseline Data

- ◎ Compare what happens before & after an intervention or program
- ◎ Assess effect of a program
- ◎ Foundation for showing performance improvement
- ◎ Needs assessment

Sample: Baseline and Post-Intervention Data (Hypothetical)

Preterm Births for Medicaid Beneficiaries in Organic County, Before & After ABC Program Implementation, in 2 Centers

	2010-2012: Before Intervention Began	2013-2014 Intervention Period	Difference between pre- intervention and intervention period
% Births < 37 weeks EGA, born to Medicaid beneficiaries, Center A	14.2%	9.6%	-4.6 percentage points
% Births < 37 weeks EGA, born to Medicaid beneficiaries, Center B	13.4%	11.3%	-2.1 percentage points

Intervention Group

- Group expected to be assigned to the program or receive the service
- Intention-to-treat: group expected to receive the service

Type of Baseline Data to Collect

- ⦿ Appropriate for measuring changes as defined by the program objectives
- ⦿ Outcome measures
- ⦿ Sample characteristics
- ⦿ Proxy measures

Identifying Data Sources

- ◎ Program data
- ◎ Alternative data sources
 - > Public sources of data
 - > Data requests
 - > Partner with a local organization

Considerations for Selecting Baseline Data

- ◎ Obtain within timeline
- ◎ Accessible
 - > Process to obtain
- ◎ Years of data available
- ◎ Data elements
- ◎ Specificity of data elements

Potential Sources of Data

- ◎ Birth Certificate
- ◎ Centers for Disease Control & Prevention
 - > Natality Public Use File
- ◎ National Center for Health Statistics
- ◎ State Vital Records & Vital Statistics
- ◎ Local health department
 - > Local WIC office
- ◎ Pregnancy Risk Assessment Monitoring System (PRAMS)
- ◎ Pregnancy Nutrition Surveillance System (PNSS)
- ◎ Local hospital
- ◎ State Medicaid program
- ◎ March of Dimes & PeriStats

U.S. Birth Certificate - 2003

U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO.

BIRTH NUMBER:

C H I L D	1. CHILD'S NAME (First, Middle, Last, Suffix)		2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Mo/Day/Yr)
	5. FACILITY NAME (If not institution, give street and number)		6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH
M O T H E R	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Mo/Day/Yr)		
	8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)		8d. BIRTHPLACE (State, Territory, or Foreign Country)		
	9a. RESIDENCE OF MOTHER-STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION		
	9d. STREET AND NUMBER		9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No
F A T H E R	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)	
C E R T I F I E R	11. CERTIFIER'S NAME: _____		12. DATE CERTIFIED: _____		13. DATE FILED BY REGISTRAR: _____
	TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> HOSPITAL ADMIN. <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		MM DD YYYY		MM DD YYYY
INFORMATION FOR ADMINISTRATIVE USE					
M O T H E R	14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: _____		City, Town, or Location: _____		
	Street & Number: _____		Apartment No.: _____		Zip Code: _____
	15. MOTHER MARRIED? (At birth, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER: _____			19. FATHER'S SOCIAL SECURITY NUMBER: _____		

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- 8th grade or less
- 9th - 12th grade, no diploma
- High school graduate or GED completed
- Some college credit but no degree
- Associate degree (e.g., AA, AS)
- Bachelor's degree (e.g., BA, AB, BS)
- Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

- No, not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish/Hispanic/Latina (Specify) _____

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- White
- Black or African American
- American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (Specify) _____
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (Specify) _____
- Other (Specify) _____

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- 8th grade or less
- 9th - 12th grade, no diploma
- High school graduate or GED completed
- Some college credit but no degree
- Associate degree (e.g., AA, AS)
- Bachelor's degree (e.g., BA, AB, BS)
- Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

- No, not Spanish/Hispanic/Latino
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish/Hispanic/Latino (Specify) _____

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

- White
- Black or African American
- American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (Specify) _____
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (Specify) _____
- Other (Specify) _____

26. PLACE WHERE BIRTH OCCURRED (Check one)

- Hospital
- Freestanding birthing center
- Home Birth: Planned to deliver at home? 9 Yes 9 No
- Clinic/Doctor's office
- Other (Specify) _____

27. ATTENDANT'S NAME, TITLE, AND NPI

NAME: _____ NPI: _____
 TITLE: MD DO CNM/CM OTHER MIDWIFE
 OTHER (Specify) _____

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? Yes No
 IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

Mother's Name

Mother's Medical Record No.

MOTHER	29a. DATE OF FIRST PRENATAL CARE VISIT MM / DD / YYYY <input type="checkbox"/> No Prenatal Care		29b. DATE OF LAST PRENATAL CARE VISIT MM / DD / YYYY		30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter "0".)	
	31. MOTHER'S HEIGHT _____ (feet/inches)		32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)		33. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)	
	34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No		35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)		36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)	
35a. Now Living Number _____ <input type="checkbox"/> None		35b. Now Dead Number _____ <input type="checkbox"/> None		36a. Other Outcomes Number _____ <input type="checkbox"/> None		
35c. DATE OF LAST LIVE BIRTH MM / YYYY		36b. DATE OF LAST OTHER PREGNANCY OUTCOME MM / YYYY		39. DATE LAST NORMAL MENSES BEGAN MM / DD / YYYY		
37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day: # of cigarettes # of packs Three Months Before Pregnancy _____ OR _____ First Three Months of Pregnancy _____ OR _____ Second Three Months of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____		38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify) _____		40. MOTHER'S MEDICAL RECORD NUMBER		
MEDICAL AND HEALTH INFORMATION	41. RISK FACTORS IN THIS PREGNANCY (Check all that apply) Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment-If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above		43. OBSTETRIC PROCEDURES (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above		46. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above		44. ONSET OF LABOR (Check all that apply) <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥12 hrs.) <input type="checkbox"/> Precipitous Labor (<3 hrs.) <input type="checkbox"/> Prolonged Labor (≥ 20 hrs.) <input type="checkbox"/> None of the above		47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery) <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the above	
			45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply) <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above			

U.S. Birth Certificate - 2003

NEWBORN INFORMATION

NEWBORN

Mother's Name

Mother's Medical Record No.

48. NEWBORN MEDICAL RECORD NUMBER	54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)	55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
49. BIRTHWEIGHT (grams preferred, specify unit) _____ 9 grams 9 lb/oz	<input type="checkbox"/> Assisted ventilation required immediately following delivery.	<input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome
50. OBSTETRIC ESTIMATE OF GESTATION: _____ (completed weeks)	<input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission	<input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above
51. APGAR SCORE: Score at 5 minutes: _____ If 5 minute score is less than 6, Score at 10 minutes: _____	<input type="checkbox"/> Newborn given surfactant replacement therapy. <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction	
52. PLURALITY - Single, Twin, Triplet, etc. (Specify) _____	<input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)	
53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____	<input type="checkbox"/> None of the above	
56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____	57. IS INFANT LIVING AT TIME OF REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown	58. IS THE INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No

Centers for Disease Control & Prevention (CDC)

- ◎ www.cdc.gov
- ◎ Data and Statistics (FastStats)
- ◎ Natality Public Use File (after 2005 does not contain geographic detail)
- ◎ “B”, Birth Data, NCVS

National Center for Health Statistics

- ◎ Standard Forms (Live Births)
- ◎ Births Final Data for 2009
- ◎ Births Preliminary Data for 2010
- ◎ Related Links – State Health Departments

State Vital Records

◎ Wisconsin Births and Infant Deaths 2010

January, 2012

- > Birth and Fertility Rates
- > Characteristics of Mother
- > Characteristics of Pregnancy and Delivery
- > **Characteristics of Newborn**
- > Mortality
- > *Statewide vs. Local and Regional

State Vital Records Analysis

- ◎ Special data request:

- > Report vs. electronic dataset for analysis
- > Current data
- > Time to obtain
- > Cost

Local Health Department

- ◎ San Antonio Metropolitan Health District
 - > Report – Health Profile 2010
 - Maternal and Child Indicators: LBW (2), Prem
 - > Report – Births Change 2009-2010 Bexar Co.
 - Averages and trends
 - > Data Requests: LBW & EGA to order
 - Medicaid only
 - Race/Ethnicity
 - Zip code and census tract

Local WIC Office

- ◎ Women Infants & Children (WIC) Program
- ◎ Supplemental foods, health care referrals, nutrition education
- ◎ Many based in local health departments
- ◎ Birth data for low income families

Pregnancy Risk Assessment Monitoring System (PRAMS)

- ◎ <http://www.cdc.gov/prams/>
- ◎ CDC & state health department surveillance project
- ◎ PRAMS Analytic Research File
- ◎ Subset of data from birth certificate records
 - > Demographic data
 - > Survey data
- ◎ CPONDER: CDC's PRAMS Online Data for Epidemiologic Research
 - > <http://www.cdc.gov/prams/CPONDER.htm>
 - > PRAMS data: 2000 through 2008

Sample CPONDER Data Table:

Green State - 2007 Morbidity - Infant

The baby's weight, classified as low birth weight (LBW) if the weight was less than or equal to 2500 grams or normal birth weight (NBW) if the weight was greater than 2500 grams

	Low Birth Weight (LBW) < 2,500 grams	Normal Birth Weight (NBW) 2,500+ grams
Percent	7.8%	92.2%
Confidence Interval (CI)	7.6 – 7.9%	92.1 – 92.4%
Sample size (n)	657	835

Pregnancy Nutrition Surveillance System (PNSS)

- Program-based public health surveillance system
- <http://aspe.hhs.gov/hsp/06/Catalog-AL-AN-NA/PNSS.htm>
- Monitors risk factors associated with infant mortality & poor birth outcomes
- Low-income women in federally-funded programs
- Voluntary reporting of programs

PNSS (continued)

- Data:

- > Indicators of maternal health & behaviors

- Published tables

- > http://www.cdc.gov/pednss/pnss_tables/index.htm

- Download data:

- > North Carolina; California; West Virginia

PNSS -- Assessment

- ◎ Table format
- ◎ 1997-2010
- ◎ National level data
- ◎ Some state-level statistics
- ◎ Birth weight: very low, low, normal, high

PNSS – Sample Data Table

2010 – Comparison of Infant Health Indicators

http://www.cdc.gov/pednss/pnss_tables/pdf/national_table8.pdf

Contributor	Birthweight % Low (rank)	Birthweight % High (rank)	Preterm % (rank)
State 1	7.5% (16)	6.5% (12)	5.2% (1)
State 2	6.4% (5)	6.8% (15)	9.3% (11)
State 3	6.1% (3)	7.4% (20)	7.4% (3)
State 4	8.2% (23)	6.4% (10)	14.1% (31)

Local Hospital

- ◎ Infants born at the facility
- ◎ Recorded in different ways
 - > Electronically, paper records
- ◎ Reports to Vital Records
 - > Electronic or hard copy format

Local Hospital – Request Process

- ◎ Professional contacts
- ◎ Contact Research Office and/or Office of Medical Information Management
- ◎ Be prepared:
 - > Outline what you need
 - > Data elements, timing, population of interest, research focus
 - > Data availability
 - > Identify request process

Local Hospital – Request Process -- Example

- ◎ Prepare & submit forms:
 - > Purpose & data needs
 - > List of names & credentials of persons who will access the data
 - > Evidence of human subjects training
- ◎ Attend panel meeting
- ◎ Data availability: 4-6 weeks initially
 - > On secured hospital-owned server

Local Hospital -- Assessment

- Format: electronic or hard copy
- Availability: few days to multiple weeks
- Data elements: depends on source

PeriData.Net – Example of Electronic System

- Wisconsin system
- Web-based perinatal database
- Electronic submission of birth information
- Hospital submit data
- Hospital own & control their own data

State Medicaid Program

- Medicaid Claims
- Medicaid Eligibility Files
- Special program:
 - > Example: Prior authorization for palivizumab
- May use existing data sources

State Medicaid Program – Claims & Eligibility Files

● Medicaid Claims

> ICD-9-CM Diagnostic Codes

- Mother: 644.21: premature birth
- Infant:
 - 765.1: prematurity
 - 765.0: extreme immaturity
- Infant weight 5th sub-digits:
 - 1: < 500 grams
 - 9: ≥ 2,500 grams

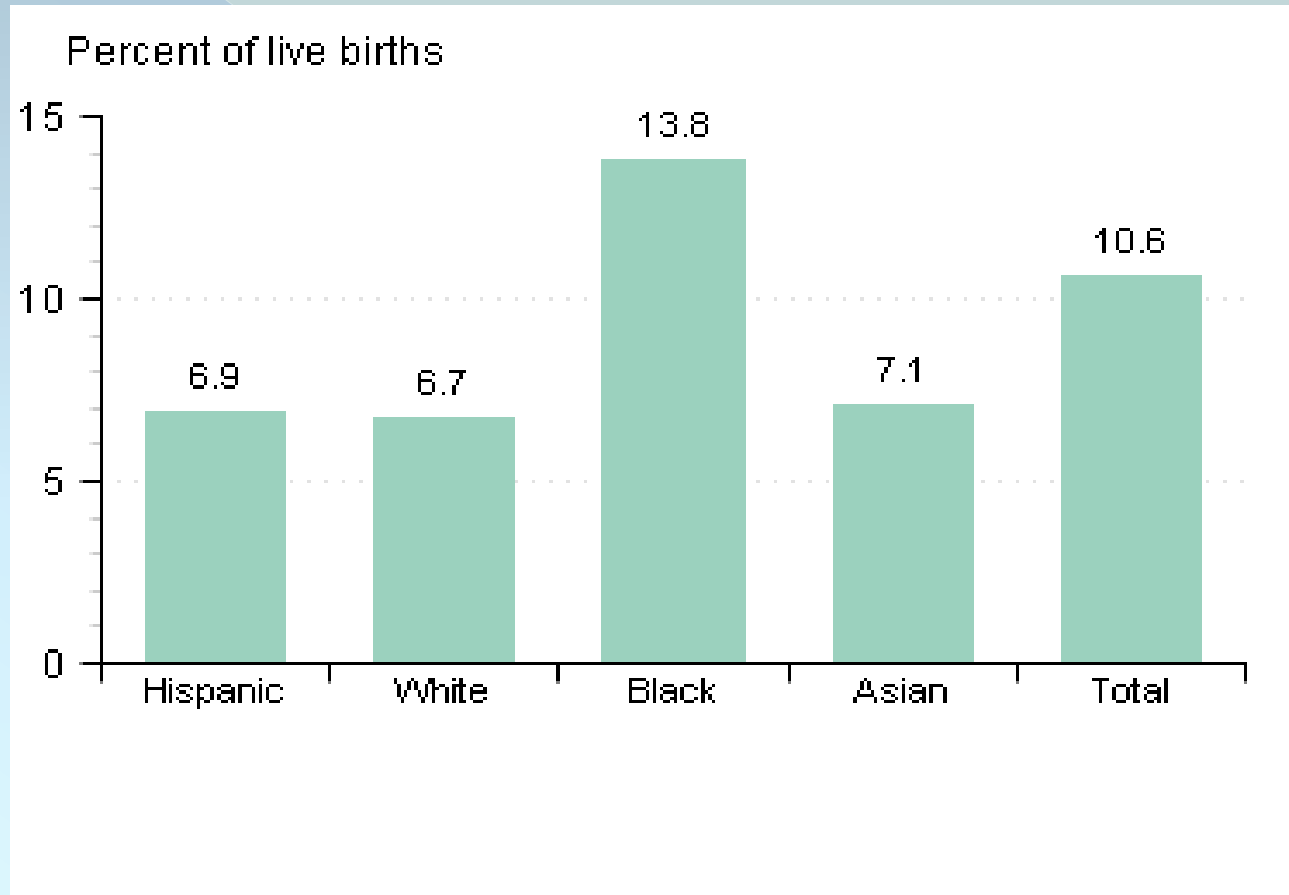
● Medicaid Eligibility Files

> Demographic data

March of Dimes -- PeriStats

- Online free resource
- March of Dimes Perinatal Data Center
- <http://www.marchofdimes.com/peristats/about.aspx>
- Pie charts or tables
- Data availability: 2009 and earlier
 - > Not preterm, moderately preterm, very preterm
 - > Low birth weight: Not, moderately, very
 - > Regional, state, some counties, some cities

March of Dimes – Peri-Stats: *Low birthweight by race/ethnicity: District of Columbia, 2007-2009 Average*



Other Data Sources

- ◎ **Kasehagen, L.** (2011). Underutilized MCH Data Sources. City Lights, 19(2), retrieved from <http://webmedia.unmc.edu/Community/CityMatch/CityLights/CityLights201105.pdf>
 - > Table 1:
 - Pregnancy Risk Assessment Monitoring System (PRAMS)
 - Pregnancy Nutrition Surveillance System (PNSS)
 - Pediatric Nutrition Surveillance System (PedNSS)
 - National Survey of Children's Health (NSCH)

Pediatric Nutrition Surveillance system (PedNSS)

- <http://www.health.ny.gov/statistics/prevention/nutrition/pednss/index.htm>
- Prevalence & trends of nutrition-related indicators
- Low-income children attending federally-funded MCH & nutrition programs
- State of New York
- Birth weight: < 2,500 grams; > 4,000 grams
- Data for children < 5 years: birth weight, breast feeding, TV viewing, smoking in household, etc.

National Survey of Children's Health

- Sponsor: Child and Adolescent Health Measurement Initiative
- Data Resource Center
- Makes survey results available to the public
- Online queries of database
- 2003 or 2007
- Aggregate US level or states
- Child health
- Not birth weight or gestational age