

Part C: Major Data Sources for Healthy People 2010

The 467 Healthy People 2010 objectives are being tracked by 190 data sources. A major data source is defined as a data system responsible for tracking five or more Healthy People 2010 objectives. There are 23 data systems that meet these criteria. A brief discussion of each (in alphabetical order) is provided in this section. Table 7 (below) lists the major data sources by the number of objectives they track. More than three-fifths (286) of the objectives are tracked with data from these sources.

Table 7	
Number of Objectives Tracked by Healthy People 2010 Major Data Sources	
Data Sources	Number of Objectives Tracked
National Health Interview Survey (NHIS)	67
National Health and Nutrition Examination Survey (NHANES)	35
National Vital Statistics System—Mortality (NVSS-M)	32
National Survey of Family Growth (NSFG)	14
National Hospital Discharge Survey (NHDS)	11
Youth Risk Behavior Surveillance System (YRBSS)	11
HIV/AIDS Surveillance System	10
Behavioral Risk Factor Surveillance System (BRFSS)	9
National Household Survey on Drug Abuse (NHSDA)	8
School Health Policies and Programs Study (SHPPS)	8
National Vital Statistics System—Nativity (NVSS-N)	8
National Profile of Local Health Departments (NPLHD)	8
National Ambulatory Medical Care Survey (NAMCS)	7
United States Renal Data System (USRDS)	7
STD Surveillance System (STDSS)	7
Medical Expenditure Panel Survey (MEPS)	6
National Hospital Ambulatory Medical Care Survey (NHAMCS)	6
Continuing Survey of Food Intake by Individuals (CSFII)	6
National Crime Victimization Survey (NCVS)	6
1999 National Worksite Health Promotion Survey (NWHPS)	5
State Tobacco Activities Tracking and Evaluation System (STATES)	5
National Notifiable Disease Surveillance System (NNDSS)	5
Monitoring the Future Study (MTF)	5

Behavioral Risk Factor Surveillance System (BRFSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
Mode of Administration	Telephone interview.
Survey Sample Design	Data collection is conducted separately by each State. Sample design uses State-level, random-digit-dialed probability samples of the adult (aged 18 years and over) population. Most States currently use disproportionate random sampling methods. Increasing State participation over time, with 15 States in 1984 and all 50 States and the District of Columbia since 1994. In 1998, State-specific sample sizes ranged from 1,499 to 6,005. The median sample size was 2,648.
Response Rates	State response rates vary from year to year. In 1998, upper-bound response rates ranged from 45 to 95 percent (median response rate: 73 percent).
Primary Survey Content	The survey consists of a core of questions asked in all States, standardized optional questions on selected topics that are administered at the State's discretion, a rotating core of questions asked every other year in all States, and State-added questions developed to address State-specific needs. Questions cover behavioral risk factors (for example, alcohol and tobacco use), preventive health measures, HIV/AIDS, health status, limitation of activity, and health care access and utilization.
Population Targeted	Civilian, noninstitutionalized population 18 years of age and older who reside in households with telephones.
Demographic Data	Gender, age, educational attainment, race/ethnicity, household income, employment status, and marital status.
Years Collected	Annually since 1984.
Schedule	Annual.
Geographic Estimates	National; State; smaller area estimates possible in some States.
Notes	The BRFSS is a partnership between State Health Departments and CDC; CDC provides about one-half of the financial resources for States to use for data collection efforts. States have substantial input on questions used by all States through the BRFSS. Many Healthy People objectives are tracked with questions that are asked every other year or are optional. Persons who do not have telephones or have telephones but are either in institutional settings or cannot be understood over the telephone are excluded.

Behavioral Risk Factor Surveillance System (BRFSS)

Contact Information	Data system homepage: http://www.cdc.gov/nccdphp/brfss Data system phone: 770-488-2455 Agency homepage: http://www.cdc.gov/nccdphp Agency phone: 770-488-5401
References	Centers for Disease Control and Prevention. <i>The Behavioral Risk Factor Surveillance System User's Guide</i> . Atlanta, GA: U.S. Department of Health and Human Services, 1998. Nelson, D.E.; Holtzman, D.; Waller, M.; et al. Objectives and design of the Behavioral Risk Factor Surveillance System. <i>American Statistical Association 1998 Proceedings of the Section on Survey Research Methods</i> . Alexandria, VA: American Statistical Association (ASA), 1998, 214-218. Powell-Griner, E. Uses and limitations of the Behavioral Risk Factor Surveillance System data. <i>American Statistical Association 1998 Proceedings of the Section on Survey Research Methods</i> . Alexandria, VA: ASA, 1998, 219-223.

Continuing Survey of Food Intake by Individuals (CSFII), 1994–96

Sponsor	U.S. Department of Agriculture (USDA), Agricultural Research Service (ARS).
Mode of Administration	Two nonconsecutive days of food intake data collected 3-10 days apart during in-person interviews using the 24-hour dietary recall method. About 2 weeks later, one adult from each household was asked to answer a series of questions about knowledge and attitudes toward dietary guidance, health, and use of food labels.
Survey Sample Design	Nationally representative stratified multistage area probability sample of U.S. noninstitutionalized civilian population, all ages. Subsampling of individuals in households. Oversampling of low-income households with incomes at or below 130 percent of the poverty threshold. For 1994–96, sample size for 1-day dietary data was 16,103; for 2-day dietary data, it was 15,303.
Response Rates	One-day response rate: 80 percent; and 2-day response rate: 76 percent.
Primary Survey Content	Kinds and amounts of foods consumed on each of 2 nonconsecutive days, sources of foods, time, name of each eating occasion. Also collected are food expenditures, shopping practices, pregnancy, lactation, nursing status, and height and weight.
Population Targeted	The civilian, noninstitutionalized population residing in all 50 States and the District of Columbia, all ages.
Demographic Data	Household: Income, poverty status, household size, region, urbanization, tenancy, participation in Food Stamp and WIC programs. Individual: Gender, age, education, race, ethnicity (Hispanic or non-Hispanic), employment status of persons 15 years of age and older.
Years Collected	1994–96.
Schedule	Periodic.
Geographic Estimates	National; four U.S. Census Bureau regions; Standard Metropolitan Statistical Areas.

Continuing Survey of Food Intake by Individuals (CSFII), 1994–96

Notes	<p>Additional outcome variables: For each of 2 days of intake and 2-day averages, food intakes in grams of 71 USDA-defined food groups and subgroups, nutrient intakes of 28 nutrients and food components, nutrient intakes expressed as percentages of the 1989 Recommended Dietary Allowances, and Pyramid servings from 30 food groups. Various components of the dietary collection methodology will change from the 1994–96 survey to the next survey planned for the year 2000. Two 24-hour recalls will be collected by telephone instead of by in-person interview. Further research will assess the impact of the changes in dietary data collection methods on the comparability of the 1994–96 and the 2000 survey estimates.</p>
Contact Information	<p>Data system homepage: http://www.barc.usda.gov/bhnrc/foodsurvey/home.htm</p> <p>Data system phone: 301-504-0170</p> <p>Agency homepage: http://www.usda.gov</p> <p>Agency phone: 202-720-2791</p>
References	<p>Ingwersen, L.A.; Haggerty, E.S.; LaComb, R.P.; et al. Continuing Survey of Food Intakes by Individuals (CSFII) Methodology: Translating Food Intakes into Data. Champagne, C., ed. <i>21st National Nutrient Databank Conference Proceedings</i>. Baton Rouge, LA, 1998.</p> <p>Mickle, S.J.; Vecchio, F.A.; and Guenther, P.M. Recent and Current Continuing Survey of Food Intakes by Individuals (CSFII) Methodology Research. Champagne, C., ed. <i>21st National Nutrient Databank Conference Proceedings</i>. Baton Rouge, LA, 1998.</p> <p>LaComb, R.P.; Green A.; and Ingwersen, L. Survey Net: Coding and Management of CSFII Food Intake Data. <i>American Statistical Association 1997 Proceedings of the Section on Survey Research Methods</i>. Alexandria, VA: American Statistical Association, 1997.</p> <p>Hama, M.Y. CSFII and HFCS Data: Issues, Problems, and Needs. Emerging Data Issues in Applied Food Demand Analysis. Proceedings of a Workshop Held by the S216, Food Demand and Consumption Behavior Regional Committee, 1993.</p>

HIV/AIDS Surveillance System

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention (NCHSTP).
Mode of Administration	Reports from health care providers are sent to the local, State, or territorial health departments. States and territories share, on a voluntary basis, de-identified data with CDC.
Survey Sample Design	All 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other U.S. territories report AIDS cases.
Response Rates	Response rates vary by geographic region and patient population. In most areas, reporting of AIDS cases is at least 85 percent complete. Reporting of deaths is about 90 percent complete.
Primary Survey Content	The AIDS case definition was modified in 1985, 1987, 1993 (for adults and adolescents), and 1994 (for pediatric cases). Data include mode of exposure to HIV, case definition category, and other clinical and demographic information.
Population Targeted	Entire population of all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and other U.S. territories. AIDS data are nationally representative.
Demographic Data	Age, gender, race, ethnicity, State and county of residence, country of birth, and living status.
Years Collected	CDC first received reports of persons with AIDS in 1981.
Schedule	Biannual. HIV/AIDS Surveillance Report is published twice a year. Supplemental reports are published on an ad hoc basis and available on the Web at http://www.cdc.gov/nchstp/hiv_aids/stats/haslink.HTM and at http://www.cdc.gov/nchstp/hiv_aids/pubs/mmwr.htm .
Geographic Estimates	National, State, and Metropolitan Statistical Area. Data release policies dictate that no data that could be used to identify a person reported to the system may be released, thus, release of data in cell sizes less than or equal to three in a given category are prohibited.
Notes	HIV/AIDS case surveillance is a population-based system.
Contact Information	Data system homepage: http://www.cdc.gov/nchstp/hiv_aids/surveillance.htm Data system phone: 404-639-2057 Agency homepage: http://www.cdc.gov/nchstp/od/nchstp.html Agency phone: 770-488-5401

HIV/AIDS Surveillance System

References

Centers for Disease Control and Prevention (CDC). Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. *Morbidity and Mortality Weekly Report* 48(RR13), 1999.

CDC. *HIV/AIDS Surveillance Report*. Year-end 1998. Vol. 10, No. 2, 1999.

Medical Expenditure Panel Survey (MEPS)

Sponsor	U.S. Department of Health and Human Services: Agency for Healthcare Research and Quality (AHRQ) and Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	<p>The MEPS comprises four linked, integrated surveys, three of which are of interest here:</p> <p>Household Component (HC): Computer-assisted, in-person interviews;</p> <p>Medical Provider Component (MPC): Telephone interviews and mailed surveys; and,</p> <p>Insurance Component (IC): Telephone interviews and mailed surveys.</p>
Survey Sample Design	Each year, the MEPS HC sample is a nationally representative subsample of the National Health Interview Survey (NHIS), which uses a stratified multistage probability design that permits a continuous sampling of 358 primary sampling units. The 1996 HC collected data on 10,500 families and 24,000 individuals who participated in the 1995 NHIS. The MPC bases its sample on the HC. The IC partially bases its sample on the HC. Data are obtained through employers, unions, or other private health insurance sources identified by the HC respondents.
Response Rates	HC: Rate varies by round, so effective response rate varies by reference period of analysis; however, for estimates of calendar year 1996, MEPS has a response rate of 70 percent, including the NHIS and three rounds of data collection. MPC: Rate is over 90 percent. IC: Rate varies by type of establishment; it is over 90 percent for governments and less for employers.
Primary Survey Content	HC: Health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. MPC: Information on medical care events from medical providers identified by HC respondents, including expense information for events covered under various managed care plans. IC: Data on types of health insurance plans, associated premiums, and numbers of plans offered.
Population Targeted	HC: Civilian noninstitutionalized families and individuals, all ages. MPC: Medical providers identified by HC respondents. IC: Health insurance companies.

Medical Expenditure Panel Survey (MEPS)

Demographic Data	Age, race, ethnicity, region, occupation, employment status, and household composition.
Years Collected	1977, 1987, and 1996 to present.
Schedule	Annual.
Geographic Estimates	National. The HC data also can be shown for the four Census regions (Northeast, Midwest, South, and West). Some State information can be provided for the IC.
Notes	AHRQ fields a new MEPS panel each year. In this design, two calendar years of information are collected from each household in a series of five rounds of data collection over a 2 1/2-year period. These data are then linked with additional information collected from the respondents' medical providers, employers, and insurance providers. This series of data collection activities is repeated each year on a new sample of households, resulting in overlapping panels of survey data.
Contact Information	Data system homepage: http://www.meps.ahrq.gov/survey.htm#target2 Data system phone: 301-594-1406 Agency homepage: http://www.meps.ahrq.gov Agency phone: 301-594-1406
References	Agency for Health Care Policy and Research (AHCPR). <i>Construction of Weights for the 1996 Medical Expenditure Panel Survey Insurance Component List Sample</i> . MEPS Methodology Report No. 8. AHRQ Pub. No. 00-0005. Rockville, MD: AHCPR, 1999. Sommers, J.P. <i>List Sample Design of the 1996 Medical Expenditure Panel Survey Insurance Component</i> . MEPS Methodology Report No. 6 AHRQ Pub. No. 99-0037. Rockville, MD: AHCPR, 1999. Sommers, J.P.; Bethel, J.; and Broene, P. <i>Construction of Weights for the 1996 Medical Expenditure Panel Survey Nursing Home Component</i> . MEPS Methodology Report No. 7. AHRQ Pub. No. 99-0045. Rockville, MD: AHCPR, 1999. Cohen, S.B.; DiGaetano, R.; and Goksel, H. <i>Estimation Procedures in the 1996 Medical Expenditure Panel Survey Household Component</i> . MEPS Methodology Report No. 5. AHRQ Pub. No. 99-0027. Rockville, MD: AHCPR, 1999. AHCPR. <i>Design and Methods of the 1996 Medical Expenditure Panel Survey Nursing Home Component</i> . MEPS Methodology Report 3. AHCPR Pub. No. 98-0041. Rockville, MD: AHCPR, 1998.

Medical Expenditure Panel Survey (MEPS)

AHCPR. *Sample Design of the 1996 Medical Expenditure Panel Survey Nursing Home Component*. MEPS Methodology Report 4. AHCPR Pub. No. 98-0042. Rockville, MD: AHCPR, 1998.

Cohen, J. *Design and Methods of the Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 1. AHCPR Pub. No. 97-0026. Rockville, MD: AHCPR, 1997.

Cohen, S. *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 2. AHCPR Pub. No. 97-0027. Rockville, MD: AHCPR, 1997.

Cohen, J.W.; Monheit, A.C.; Beauregard, K.M.; et al. *The Medical Expenditure Panel Survey: A National Health Information Resource*. *Inquiry* 33:373-389, 1996/1997. Also available as AHCPR Pub. No. 97-R043. Washington, DC: AHCPR, 1997.

Monitoring the Future Study (MTF)

Sponsor	U.S. Department of Health and Human Services, National Institutes of Health (NIH), National Institute on Drug Abuse (NIDA).
Mode of Administration	Self-administered paper and pencil questionnaire completed by a random sample of 8th, 10th, and 12th graders.
Survey Sample Design	The Monitoring the Future Study utilizes a three-stage probability design that includes primary sampling units (PSUs), schools within PSUs, and students within schools. Up to 350 students per school are selected, either by randomly sampling classrooms or by some other random method that is convenient for the school and judged to be unbiased. Beginning in 1991, national samples of 8th and 10th graders were included. Approximately 50,000 responses are collected annually from all three grades combined.
Response Rates	The 1998 response rate for 8th, 10th, and 12th graders was 88, 87, and 82 percent, respectively.
Primary Survey Content	Cigarette, alcohol, and illicit drug use; attitudes and beliefs regarding drug use; attitudes of significant others regarding drug use; drug exposure and availability; lifestyle values, attitudes, and behaviors; participation in organized activities, leisure time activities, and religion; deviant behavior and victimization; health; college plans; and demographic data. Drug use and related attitudes are the key variables.
Population Targeted	Students in 8th, 10th, and 12th grades from public and private schools in the coterminous United States.
Demographic Data	Gender, race/ethnicity, parental education (used as a proxy for socioeconomic status). Data on sexual orientation are not collected.
Years Collected	1975 through present.
Schedule	Annual.
Geographic Estimates	National, census region, and population density (Large Metropolitan Statistical Areas [MSAs], other MSA, non-MSA).
Notes	To obtain estimates, numerator and denominator data are weighted to reflect differential probabilities of selection at three stages of selection: primary areas (counties or groups of counties) within stratum, schools within primary areas, and students within schools. Final weights are normalized to average unity, thus the numerator and denominator estimates reflect the sample design but not population totals. This weighting scheme allows the estimates to be representative of the population of students in public and private schools in the continental United States.

Monitoring the Future Study (MTF)

Contact Information

Data system homepage:
<http://www.isr.umich.edu/src/mtf/index.html>
Data system phone: Not available
Agency homepage: <http://www.nida.nih.gov>
Agency phone: 301-443-6637

References

Johnston, L.D.; Bachman, J.G.; and O'Malley, P.M. *Monitoring the Future: Questionnaire Responses From the Nation's High School Seniors*. Ann Arbor, MI: Institute for Social Research, 1995.

O'Malley, P.M. *The Monitoring the Future Study*. In: Jaffe, J.H., et al., eds. *Encyclopedia of Drugs and Alcohol*. New York, NY: Macmillan, 1995.

Wallace, J.M., Jr., and Bachman, J.G. Validity of self-reports in student-based studies on minority populations: Issues and concerns. In: De La Rosa, M., and Andradoss, J.L., eds. *Drug Abuse Among Minority Youth: Advances in Research and Methodology*. *NIDA Research Monograph* No. 130:167-200. Rockville, MD: National Institute on Drug Abuse, 1993.

National Ambulatory Medical Care Survey (NAMCS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Field personnel meet with participating physicians and instruct them in survey data collection methods. Physicians are asked to complete 1-page questionnaires on a sample of their office visits during an assigned reporting period.
Survey Sample Design	The NAMCS utilizes a three-stage survey design that involves probability samples of primary sampling units (PSUs), physician practices within PSUs, and patient visits within physician practices. Participating physicians are randomly assigned to a 1-week reporting period during the survey year, and a systematic random sample of patient visits during that period is selected by the physician, using a visit sampling rate that varies by the size of the practice. Sample data are weighted to produce national estimates of office visits. About 2,500 physicians were sampled in 1998 and more than 23,000 survey encounter forms were completed.
Response Rates	The survey response rate has averaged around 70 percent.
Primary Survey Content	Information is obtained on various aspects of office visits, including physician practice characteristics, patient characteristics, and other visit characteristics. The survey form is redesigned every 2 years to address changing health data needs. Among the items collected are patient's age, gender, race, and ethnicity; patient's expressed reason for visiting the physician; place, cause, and intentionality of injury, if any; physician's diagnoses; diagnostic services ordered or provided; therapeutic services; ambulatory surgical procedures performed; medications; providers seen; visit disposition; time spent with physician; and expected source of payment.
Population Targeted	The basic sampling unit is the physician-patient encounter or visit. Visits made to the offices of nonfederally employed, office-based physicians who are classified by the American Medical Association or the American Osteopathic Association as being primarily engaged in direct patient care. The specialties of anesthesiology, pathology, or radiology are not included. Not included are contacts by telephone, visits made outside the physician's office, visits in hospitals or institutional settings, and visits made for administrative purposes only.

National Ambulatory Medical Care Survey (NAMCS)

Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	Annual from 1973–81; again in 1985; resumed an annual schedule in 1989.
Schedule	Annual.
Geographic Estimates	National; four regions.
Notes	The NAMCS is a visit-based survey rather than a population-based survey. Therefore, estimates of incidence and prevalence of disease cannot be computed. The survey is cross-sectional in nature. Multiple visits may be made by the same person within the sample.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm Data system phone: 301-458-4600 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Woodwell, D.A. <i>National Ambulatory Medical Care Survey: 1997 Summary</i> . Advance data from Vital and Health Statistics, No. 305. Hyattsville, MD: National Center for Health Statistics, 1999.

National Crime Victimization Survey (NCVS)

Sponsor	U.S. Department of Justice, Bureau of Justice Statistics, Office of Justice Programs.
Mode of Administration	Interview: With the exception of the first and the fifth of a total of seven interviews, all interviews are done by phone using computer-assisted telephone interviewing (CATI). The first and fifth interviews are personal interviews using computer-assisted personal interviewing (CAPI).
Survey Sample Design	The NCVS uses a stratified, multistage cluster sample. Primary sampling units (PSUs) consist of counties, groups of counties, or large metropolitan areas. The 1994 survey sample households were drawn from the 1980-based sample design. Data are collected every year from a sample of approximately 50,000 households that includes about 100,000 people aged 12 years and older. PSUs remain in the sample for a total of 3 years. A total of seven interviews are conducted at 6-month intervals during the 3-year process.
Response Rates	Response rates have consistently remained around 95 percent (96 percent of eligible housing units and 92 percent of individuals in interviewed households).
Primary Survey Content	The NCVS counts incidents not reported to police and is one of two U.S. Department of Justice measures of crime in the United States. The survey contains a screening section with detailed questions and cues on victimizations and situations within which crimes may take place. Interviewers follow up positive responses and collect details about victimizations in incident reports.
Population Targeted	Noninstitutionalized population aged 12 years and older residing in the United States.
Demographic Data	Age, gender, race, ethnicity, and income. Property crimes include data on age, race, ethnicity, and household size.
Years Collected	1974 to present.
Schedule	Annual.
Geographic Estimates	National.
Contact Information	Data system homepage: http://www.oip.usdoj.gov/bjs/cvict.htm#ncvs Data system phone: 202-616-3494 Agency homepage: http://www.oip.usdoj.gov/bjs Agency phone: 202-307-0770

National Crime Victimization Survey (NCVS)

References

Kinderman, C.; Lynch, J.; and Cantor, D. *Effects of the Redesign on Victimization Estimates*. Washington, DC: Bureau of Justice Statistics, 1997.

Hubble, D. *The National Crime Victimization Survey Redesign: New Questionnaire and Procedures Development and Phase-In Methodology*. Orlando, FL: Annual meetings of the American Statistical Association, 1995.

Persley, C. *The National Crime Victimization Survey Redesign: Measuring the Impact of New Methods*. Orlando, FL: Annual meetings of the American Statistical Association, 1995.

Biderman, A.D.; Cantor, D.; Lynch, J.P.; et al. *Final Report of Research and Development for the Redesign of the National Crime Victimization Survey*. Washington, DC: Bureau of Social Sciences Research, Inc., 1986.

Hubble, D. *The National Crime Survey's New Questionnaire Phase-in: Preliminary Results*. Tucson, AZ: International Conference on Measurement Errors in Surveys, 1990.

Hubble, D., and Wilder, B.E. *Preliminary Results from the National Crime Survey CATI Experience*. New Orleans, LA: Proceedings of the American Statistical Association: Survey Methods Section, 1988.

National Health and Nutrition Examination Survey (NHANES)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	In-person interview in the household and in a private setting in the mobile examination center. Standardized physical examinations and medical tests in mobile examination centers. Conducted in English and Spanish.
Survey Sample Design	The NHANES uses a stratified multistage probability sample, nationally representative of the U.S. civilian noninstitutionalized population. Approximately 5,000 people are examined at 15 locations each year. In NHANES III, children aged 2 months to 5 years, persons aged 70 years and over, African Americans, and Mexican Americans were oversampled. Beginning in 1999, African Americans, Mexican Americans, adolescents, and older persons will be oversampled.
Response Rates	In NHANES III (1988–94): Household interview response rate was 86 percent; and the medical examination response rate was 78 percent.
Primary Survey Content	Chronic disease prevalence and conditions (including undiagnosed conditions), risk factors, diet and nutritional status, immunization status, infectious disease prevalence, health insurance, and measures of environmental exposures. Other topics addressed include hearing, vision, mental health, anemia, diabetes, cardiovascular disease, osteoporosis, obesity, oral health, mental health, and physical fitness. Beginning in 1999, new topics are cardiorespiratory fitness, physical functioning, lower extremity disease, full body DXA for body fat as well as bone density, and tuberculosis infection.
Population Targeted	For NHANES III, the civilian noninstitutionalized population residing in the United States aged 2 months and over. Beginning in 1999, people of all ages are included.
Demographic Data	Gender, age, education, race/ethnicity, place of birth, income, occupation, and industry.
Years Collected	From 1960 to 1994, a total of seven national examination surveys have been conducted. Beginning in 1999, the survey has been conducted continuously.
Schedule	Periodic (1960–94); annual beginning in 1999.
Geographic Estimates	National; four U.S. Census Bureau regions.

Notes	Although the new NHANES will be conducted on a yearly basis, the annual sample size will be too small to provide reliable estimates for many measures and for most subgroups. Most analyses will require 3 years of data for reliable estimates.
Contact Information	<p>Data system homepage: http://www.cdc.gov/nchs/nhanes.htm</p> <p>Data system phone: 301-458-4667</p> <p>Agency homepage: http://www.cdc.gov/nchs</p> <p>Agency phone: 301-458-INFO (4636)</p>
References	<p>National Center for Health Statistics. Plan and operation of the third National Health and Nutrition Examination Survey, 1988–94. National Center for Health Statistics (NCHS). <i>Vital and Health Statistics</i> 1(32), 1994.</p> <p>Ezzati, T.M.; Massey, J.T.; Waksberg, J.; et al. Sample design: Third National Health and Nutrition Examination Survey. NCHS. <i>Vital and Health Statistics</i> 2(113), 1992.</p> <p>Maurer, K.R. Plan and operation of the Hispanic Health and Nutrition Examination Survey, 1982–84. NCHS. <i>Vital and Health Statistics</i> 1(19), 1985.</p>

National Health Interview Survey (NHIS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Personal interview in households using computer-assisted personal interviewing (CAPI), administered by professional interviewers, and conducted in English and Spanish (for CAPI, Spanish version was initiated in mid-1998).
Survey Sample Design	The NHIS uses a stratified multistage probability design that permits a continuous sampling of 358 primary sampling units (PSUs), with over-sampling of African Americans and Hispanics. A typical NHIS sample for the data collection years 1995–2004 consists of approximately 7,000 second-stage units (segments) within a PSU. The expected sample of 43,000 occupied respondent households yields a probability sample of about 111,000 persons. The survey is designed so that the sample scheduled for each week is representative of the target population and the weekly samples are additive over time.
Response Rates	Response rates for the basic NHIS core questionnaire have ranged from 91 to 96 percent over the years, with rates of sample person components generally ranging from 85 to 90 percent of eligible respondents. Response rates for special health topics (supplements) have generally also been in this lower range. The effect, if any, of the new CAPI technology is not yet known.
Primary Survey Content	Information is obtained on demographic characteristics, illnesses, injuries, impairments, chronic conditions, utilization of health resources, health insurance, and other health topics. The core household interview asks about everyone in the household. Additional questions are asked of one sample adult and one sample child (under 18 years) per family in the household. The sample adult questionnaire includes chronic health conditions and limitations in activity, health behaviors, health care access, health care provider contacts, immunizations, and AIDS knowledge and attitudes. The sample child questionnaire includes questions about chronic health conditions, limitation of activities, health status, behavior problems, health care access and utilization, and immunizations. Child data are proxy-reported by a parent or other knowledgeable adult respondent. Adult sample person data are all self-reported. Special modules are fielded periodically, and cover areas such as cancer, prevention, and disability.
Population Targeted	Civilian noninstitutionalized population residing in the United States, all ages.

National Health Interview Survey (NHIS)

Demographic Data	Gender, age, race/Hispanic ethnicity, education, income, marital status, place of birth, industry, and occupation.
Years Collected	Continuously since 1957. Current sample design began in 1995; current questionnaire design began in 1997.
Schedule	Annual.
Geographic Estimates	National; four U.S. Census Bureau regions; some of the 10 HHS regions, some States; metropolitan and nonmetropolitan areas.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/nhis.htm Data system phone: 301-458-4001 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Hendershot, G.; Adams, P.; Marano, M.; et al. Current estimates from the National Health Interview Survey, 1996. National Center for Health Statistics (NCHS). <i>Vital and Health Statistics</i> 10(200), 1999. Questionnaires from the National Health Interview Survey, 1985–89. NCHS. <i>Vital and Health Statistics</i> 1(31), 1993. Massey, J.T.; Moore, T.F.; Parsons, V.L.; et al. Design and estimation for the National Health Interview Survey, 1985–94. NCHS. <i>Vital and Health Statistics</i> 2(110), 1989.

National Hospital Ambulatory Medical Care Survey (NHAMCS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Hospital staff are asked to complete one-page questionnaires (Patient Record forms) on a sample of their patient visits during an assigned reporting period.
Survey Sample Design	The NHAMCS utilizes a four-stage probability design that involves samples of primary sampling units (PSUs), hospitals within PSUs, clinics within hospitals, and patient visits within clinics. Hospital staff were asked to complete Patient Record forms for a systematic random sample of patient visits occurring during a randomly assigned 4-week reporting period during the survey year. Sample data are weighted to produce national estimates of patient visits. About 400 emergency departments participated in 1998 and more than 24,000 Patient Record forms were completed. About 230 outpatient departments (OPD) participated in 1998 and about 30,000 Patient Record forms were completed.
Response Rates	The response rates are about 95 percent.
Primary Survey Content	NHAMCS includes two files: ED visits and OPD visits. Information is obtained on various aspects of patient visits, including patient characteristics, physician characteristics, and other visit characteristics. The survey form is redesigned every 2 years to address changing health data needs. Among the items collected are: patient's age, gender, race, and ethnicity; patient's expressed reason for visit; place, cause, work-relatedness, and intentionality of injury, if any; physician's diagnoses; diagnostic services ordered or provided; procedures provided; medications ordered, supplied, administered or continued; providers seen; visit disposition; immediacy with which patient should be seen; time spent with physician; and, expected source of payment.
Population Targeted	The basic sampling unit is the patient visit. Included in the survey are in-person visits by patients to EDs and OPDs of noninstitutional general and short-stay hospitals, exclusive of Federal, military, and Veterans Administration hospitals, located in the 50 States and the District of Columbia. Telephone contacts are excluded.
Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	Annual since 1992.
Schedule	Annual.
Geographic Estimates	National, four U.S. Census Bureau regions.

National Hospital Ambulatory Medical Care Survey (NHAMCS)

Notes	The NHAMCS is a visit-based survey rather than a population-based survey. Estimates of visits per person per year can be produced using U.S. Census Bureau civilian noninstitutionalized population estimates. The survey is cross-sectional in nature. Multiple visits may be made by the same person within the sample.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm Data system phone: 301-458-4600 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	McCaig, L.F.; and McLemore, T. Plan and operation of the National Hospital Ambulatory Medical Care Survey. National Center for Health Statistics. <i>Vital and Health Statistics</i> 1(34), 1994.

National Hospital Discharge Survey (NHDS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Manual sample selection and abstraction of inpatient medical records by field personnel or automated data collection through the purchase of electronic files from commercial abstracting sources, States, or hospitals.
Survey Sample Design	The NHDS utilizes a three-stage probability design that includes primary sampling units (PSUs) used for the 1985–94 NHIS, hospitals within PSUs, and discharges within hospitals. The largest hospitals were selected with certainty. The annual number of records included in the survey is approximately 300,000.
Response Rates	The survey response rate averages between 92 and 95 percent annually.
Primary Survey Content	Variables collected include: age; gender; race; ethnicity; admission and discharge dates (length of stay); discharge status; source of payment; hospital size, ownership, and region; from 1-7 diagnoses coded using the ICD-9-CM; and, from 0-4 procedures using the ICD-9-CM.
Population Targeted	Hospital discharges from short-stay noninstitutional hospitals and general and children's general hospitals regardless of length of stay, exclusive of military and U.S. Department of Veteran Affairs hospitals, located within the 50 States and the District of Columbia.
Demographic Data	Patient's age, gender, race, and ethnicity.
Years Collected	1965 to present.
Schedule	Annual.
Geographic Estimates	National, four U.S. Census Bureau regions.
Notes	Data on race are not available for some hospitals because the hospitals provide data from billing forms that do not include race as a required item. A comparison of NHDS data with data for those who reported being hospitalized in the NHIS indicated that under reporting for whites was about 30 percent in 1992; the difference for African Americans was not statistically significant. Hispanic origin is not reported for 75 percent of the NHDS records in 1992. (Kozak, L.J. Under reporting of race in the National Hospital Discharge Survey. Advance Data from Vital and Health Statistics, No. 265. Hyattsville, MD: National Center for Health Statistics, 1995.)

National Hospital Discharge Survey (NHDS)

Contact Information	Data system homepage: http://www.cdc.gov/nchs/about/major/hdasd/nhds.htm Data system phone: 301-458-4321 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Graves, E.J., and Owings, M.F. 1996 Summary: National Hospital Discharge Survey. <i>Advance data from Vital and Health Statistics</i> . No. 301. Hyattsville, MD: National Center for Health Statistics (NCHS), 1998. Haupt, B.J., and Kozak, L.J. Estimates from two survey designs: National Hospital Discharge Survey. NCHS. <i>Vital and Health Statistics</i> 13 (111), 1992. National Center for Health Statistics. Detailed diagnoses and procedures: National Hospital Discharge Survey. NCHS. <i>Vital and Health Statistics</i> 13, Published annually.

National Household Survey on Drug Abuse (NHSDA)

Sponsor	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).												
Mode of Administration	Questionnaires are administered in the home by professional survey administrators. Starting in 1999, computer-assisted personal interview (CAPI) and audio computer-administered self interview (ACASI) for sensitive questions are used. Prior surveys used paper and pencil. Self-respondents only; no respondent identifiers are collected.												
Survey Sample Design	Multistage national probability sample with oversampling of youth. In 1997, the survey was administered to 24,505 persons aged 12 years and older, including 7,844 persons aged 12 to 17 years. Oversample of young people (aged 12 to 34 years), African Americans, and Hispanics in 1985–98 surveys. Oversample in California and Arizona in 1997 and 1998. In 1999, the sample size increased to 70,000 people, including 3,600 to 4,600 for the eight most populous States, and 900 to 1,000 for the other States. It included 25,000 youth aged 12 to 17 years, 22,500 young adults aged 18 to 25, and 22,500 adults aged 26 years and older.												
Response Rates	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>For 1997:</u></th> <th style="text-align: center;"><u>Total</u></th> <th style="text-align: center;"><u>12 to 17 years</u></th> </tr> </thead> <tbody> <tr> <td>Household response rate</td> <td style="text-align: center;">93%</td> <td style="text-align: center;">93%</td> </tr> <tr> <td>Individual response rate</td> <td style="text-align: center;">78%</td> <td style="text-align: center;">83%</td> </tr> <tr> <td>Overall response rate</td> <td style="text-align: center;">73%</td> <td style="text-align: center;">77%</td> </tr> </tbody> </table> <p>Response rates are slightly higher among the Hispanic and African American populations.</p>	<u>For 1997:</u>	<u>Total</u>	<u>12 to 17 years</u>	Household response rate	93%	93%	Individual response rate	78%	83%	Overall response rate	73%	77%
<u>For 1997:</u>	<u>Total</u>	<u>12 to 17 years</u>											
Household response rate	93%	93%											
Individual response rate	78%	83%											
Overall response rate	73%	77%											
Primary Survey Content	In 1999, the survey contained initiation, recency, and frequency of use of alcohol, tobacco (including smokeless, cigarettes, and cigars), marijuana and other illicit drugs; prescription drug misuse; treatment and prevention-related items.												
Population Targeted	Civilian noninstitutionalized population residing in the United States ages 12 and older.												
Demographic Data	Gender, age, race/ethnicity, education, marital status, employment, income.												
Years Collected	1971 to present. Continuous since 1992.												
Schedule	Annual.												

National Household Survey on Drug Abuse (NHSDA)

Geographic Estimates	<p>National, regional.</p> <p>Beginning in 1999, direct State estimates are possible for California, Texas, Michigan, Pennsylvania, New York, Florida, Illinois, and Ohio, and model-based estimates are possible for other States.</p>
Notes	<p>The sample size, the mode of administration and the survey content changed in 1999.</p>
Contact Information	<p>Data system homepage: http://www.samhsa.gov/OAS/nhsda/nhsda97/httoc.htm</p> <p>Data system phone: Not available</p> <p>Agency homepage: http://www.samhsa.gov</p> <p>Agency phone: 800-729-6686</p>
References	<p>Harrell, A.V. The validity of self-reported drug use data: The accuracy of responses on confidential self-administered answer sheets, In: Harrison, L., and Hughes, A., eds. <i>The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates</i>. NIDA Research Monograph 167, NIH Pub. No. 96-4147, Washington, DC: Superintendent of Documents, U.S. Government Printing Office (GPO), 1997.</p> <p>Harrison, L., and Hughes, A., eds. <i>The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates</i>. NIDA Research Monograph 167, NIH Pub. No. 96-4147, Washington, DC: Superintendent of Documents, GPO, 1997.</p> <p>Substance Abuse and Mental Health Services Administration. <i>Development and Implementation of a New Data Collection Instrument for the 1994 National Household Survey on Drug Abuse</i>. HHS Pub. No. (SMA)96-3084, Washington, DC: Superintendent of Documents, GPO, 1996.</p> <p>Gfroerer, J. <i>An Overview of the National Household Survey on Drug Abuse and Related Methodological Research</i>. Proceedings of the Survey Research Section of the American Statistical Association, Joint Statistical Meetings, Boston, MA, August 1992.</p> <p>American Statistical Association. Turner, C.F.; Lessler, J.T.; and Gfroerer, J.C. <i>Survey Measurement of Drug Use: Methodological Studies</i>. National Institute on Drug Abuse. DHHS Pub. No. (ADM) 92-1929, 1992.</p> <p>Needle, R.H.; Jou, S.C.; and Su, S.S. The impact of changing methods of data collection on the reliability of self-reported drug use of adolescents. <i>American Journal of Drug and Alcohol Abuse</i> 15(3):275-289, 1989.</p>

**National Notifiable Disease Surveillance System
(NNDSS) and National Electronic
Telecommunications System for Surveillance
(NETSS)**

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Epidemiology Program Office (EPO).
Mode of Administration	Reports are submitted by health care providers and clinical laboratories to the local, county, or State health departments. Weekly transmission of all data reported to CDC is overseen and administered by the State health department.
Survey Sample Design	States determine the diseases that are nationally notifiable, the data that are collected, and method of reporting.
Response Rates	Varies by disease and State. Severe clinical illnesses are more likely to be reported. Persons with clinically mild diseases—usually not associated with severe consequences—may not be seen in health care settings or may not be reported by health care providers. Underreporting is a major limitation of this system.
Primary Survey Content	The Council of State and Territorial Epidemiologists and CDC develop the list of diseases and conditions that are considered nationally notifiable (52 in 1999). However, each State determines which diseases and conditions from the list will be reported from that State; many States also include other diseases and conditions in addition to those on the list of nationally notifiable diseases and conditions. States generally report the internationally quarantineable diseases, in compliance with the World Health Organization regulations. Data include demographic characteristics and other epidemiologically important information.
Population Targeted	Entire population of all States, District of Columbia, and five U.S. territories.
Demographic Data	Race, ethnicity, age, gender.
Years Collected	By 1928, all States, the District of Columbia, Hawaii, and Puerto Rico were participating in public health reporting for nearly 30 specified conditions. In 1984, a system was developed for the electronic transfer of individual case record data, and by 1990, each of the 50 States had begun participating in the system, which was then renamed NETSS. NETSS provides both individual and summary records.
Schedule	Data are transmitted to CDC from the States each week. National data are published annually.
Geographic Estimates	National, regional, State, county.

**National Notifiable Disease Surveillance System
(NNDSS) and National Electronic
Telecommunications System for Surveillance
(NETSS)**

Notes	Although State health department staff and their CDC colleagues attempt to obtain complete demographic and epidemiologic information, some data (particularly race and ethnicity) are not available for some cases of disease. Laws, regulations, and mandates for public health reporting (including specific data items that are reported) are under the authority of individual States, and in some States, race and ethnicity may not be approved for reporting to the national level. Race and ethnicity data may also be unknown when cases are reported from a laboratory or when cases are reported as aggregate disease totals.
Contact Information	Data system homepage: http://www.cdc.gov/epo/dphs/netss.htm Data system phone: 404-639-0080 Agency homepage: http://www.cdc.gov/epo Agency phone: 404-639-3636

National Profile of Local Health Departments (NPLHD)

Sponsor	Conducted by the National Association of County and City Health Officials, funded through a U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), cooperative agreement.
Mode of Administration	Self-administered questionnaires.
Survey Sample Design	Census of U.S. local health departments.
Response Rates	The response rate for the 1996–97 NPLHD was 88 percent (2,492 of 2,834 local health departments).
Primary Survey Content	Descriptive data on local health departments nationwide, including jurisdiction type, services provided, staff size, community partnerships and collaborative relationships, managed care, and expenditures.
Population Targeted	Local health departments in the United States.
Demographic Data	Jurisdiction type, population size.
Years Collected	1989; 1992–93; 1996–97.
Schedule	Periodic.
Geographic Estimates	National, 10 HHS Regions, State, and county. Data will be geo-coded.
Notes	The NPLHD is a cross-sectional survey, not a longitudinal survey. Questions change from survey to survey.
Contact Information	Data system homepage: http://www.naccho.org Data system phone: 202-783-5550 Agency homepage: http://www.cdc.gov/phppo Agency phone: 770-488-2460
References	National Association of County and City Health Officials. <i>1992–1993 National Profile of Local Health Departments: National Surveillance Series</i> . Atlanta, GA: Centers for Disease Control and Prevention, 1995.

National Survey of Family Growth (NSFG)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Computer-assisted personal interview (CAPI) by professional female interviewers. In addition, a self-administered audio section for more sensitive topics (ACASI), in which respondents hear questions on headphones (and read on a computer screen) and enter responses on the computer themselves.
Survey Sample Design	The 1995 survey was a multistage probability design consisting of households that had been interviewed in 198 PSUs in the National Health Interview Survey in 1993. Of the 13,795 eligible females in the sample, 10,847 were interviewed. Black and Hispanic females were oversampled.
Response Rates	Response rates have averaged around 80 percent for prior cycles; in the most recent cycle, 1995, the response rate was 79 percent.
Primary Survey Content	The NSFG contains data on factors affecting birth and pregnancy rates, adoption, and maternal and infant health. These factors include sexual activity, marriage, divorce and remarriage, unmarried cohabitation, contraception and sterilization, infertility, breastfeeding, pregnancy loss, low birthweight, and use of medical care for family planning and infertility.
Population Targeted	Civilian noninstitutionalized females aged 15 to 44 years residing in the United States.
Demographic Data	Age, race, Hispanic ethnicity, family income, educational attainment.
Years Collected	1973; 1976; 1982; 1988; and 1995. Future surveys will be conducted in 2001, 2004, and 2007.
Schedule	Periodic.
Geographic Estimates	National; four U.S. Census Bureau regions; metropolitan and nonmetropolitan areas; some of the 10 HHS regions.
Notes	The sample size of future surveys will increase. Beginning in 2001, males will be sampled as well as females. Persons aged 15 to 19 and 20 to 24 years will be oversampled as well as black and Hispanic population groups.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/nsfg.htm Data system phone: 301-458-4222 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)

National Survey of Family Growth (NSFG)

References

Potter, F.J.; Iannacchione, V.G.; Mosher, W.D.; et al. Sampling weights, imputation, and variance estimation in the 1995 National Survey of Family Growth. National Center for Health Statistics (NCHS). *Vital and Health Statistics* 2(124), 1998.

Kelly, J.E.; Mosher, W.D.; Duffer, A.P.; et al. Plan and operation of the 1995 National Survey of Family Growth. NCHS. *Vital and Health Statistics* 1(36), 1997.

Waksberg, J.; Sperry, S.; Judkins, D.; et al. National Survey of Family Growth, Cycle IV, evaluation of linked design. NCHS. *Vital and Health Statistics* 2(117), 1993.

Judkins, D.R.; Mosher, W.D., and Botman, S. National Survey of Family Growth: Design, estimation, and inference. NCHS. *Vital and Health Statistics* 2(109), 1991.

Waksberg, J., and Northrup, D.R. Integration of sample design for the National Survey of Family Growth, Cycle IV, with the National Health Interview Survey. NCHS. *Vital and Health Statistics* 2(96), 1985.

National Vital Statistics System, Mortality (NVSS-M)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Administrative records (death certificates) completed by physicians, coroners, medical examiners, and funeral directors are filed with State vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Beginning with 1989, revised standard certificates replaced the 1978 versions; the next scheduled revision is 2003. Demographic information on the death certificate is provided by the funeral director and is based on information supplied by an informant. Medical certification of cause of death is provided by the physician, medical examiner, or coroner.
Survey Sample Design	NVSS mortality files include data for the 50 States, the District of Columbia, and the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Marianas. All deaths occurring in those areas are included (approximately 2.2 to 2.3 million annually). Data for Healthy People 2010 are based only on resident deaths filed in the 50 States and the District of Columbia. Deaths to nonresidents of the United States are not included.
Response Rates	N/A.
Primary Survey Content	Year of death, place of decedent's residence, place death occurred, age at death, day of week and month of death, Hispanic origin, race, marital status (beginning in 1979), place of birth, gender, underlying and multiple causes of death for all States, injury at work (beginning in 1993), hospital and patient status, educational attainment (beginning in 1989) for selected States, and occupation and industry (beginning in 1984) for selected States.
Population Targeted	The U.S. population.

National Vital Statistics System, Mortality (NVSS-M)

Demographic Data	Gender, race, Hispanic origin (beginning in 1984), age at death, place of decedent's residence, educational attainment (beginning in 1989) for selected States, marital status, and industry and occupation for selected States. Race and ethnic origin are separate items on the death certificate. Beginning with 1992 data, California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington reported expanded Asian and Pacific Islander categories of Asian Indian, Korean, Vietnamese, Samoan, and Guamanian. The rest of the States reported a combined Other Asian and Pacific Islander category in addition to the categories of white, black, American Indian, Chinese, Hawaiian, Japanese, and Filipino that all States report. As of 1997, all States report Hispanic origin. The categories reported include Mexican, Puerto Rican, Cuban, Central and South American, and Other Hispanic.
Years Collected	The data system began in 1900 but not all States participated before 1933. Coverage for deaths has been complete since 1933.
Schedule	Annual.
Geographic Estimates	National, regional, State, and county. Beginning with 1989 data, some changes were initiated to increase confidentiality protection. Identifying information including date of death and geographic identifiers for counties of less than 100,000 persons are not available for public use.
Contact Information	Data system homepage: http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm Data system phone: 301-458-4555 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-4666
References	Hoyert, D.L.; Kochanek, K.D.; and Murphy, S.L. Deaths: Final Data for 1997. <i>National Vital Statistics Reports</i> 19(Suppl. 47). Hyattsville, MD: National Center for Health Statistics (NCHS), 1999. NCHS. <i>Technical Appendix. Vital Statistics of the United States, 1992</i> . Vol. II, Mortality, Part A. HHS Pub. No. (PHS) 96-1101. Washington, DC: U.S. Government Printing Office, 1996.

National Vital Statistics System - Natality (NVSS-N)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).
Mode of Administration	Hospital and attendants at delivery are responsible for completion of administrative records (birth certificates), which are filed with State vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Demographic information is provided by the mother. Medical and health information is generally based on hospital and other records. Beginning with 1989, revised standard certificates replaced the 1978 versions. The next scheduled revision is in 2003.
Survey Sample Design	NVSS natality data include data for the 50 States, the District of Columbia, and the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Marianas. All births are included (approximately 3.9 to 4.0 million annually). Data for Healthy People 2010 are based only on resident births filed in the 50 States and the District of Columbia. Births to nonresidents of the United States are not included.
Response Rates	N/A.
Primary Survey Content	Year of birth, place of birth, prenatal care, demographic information and health status of baby, demographic information of mother and father, pregnancy history of mother, medical and health data about the delivery, pregnancy, and mother.
Population Targeted	All registered births in the United States.
Demographic Data	Gender of baby. Race, Hispanic origin, age, educational attainment, marital status of mother, and live-birth order.
Years Collected	The data system began in 1900 but not all States participated before 1933. Before 1972, only a 50 percent sample of birth certificates was received. Beginning 1972 all birth certificates are included from States participating in the Vital Statistics Cooperative Program (VSCP), with other States continuing to provide data from a 50 percent sample of birth certificates. Beginning 1985, the natality file is based on 100 percent of birth certificates in all States and the District of Columbia.
Schedule	Annual.
Geographic Estimates	National, regional, State, county, and city. Detailed data for counties and cities of 100,000 or more population.

National Vital Statistics System - Natality (NVSS-N)

Contact Information	Data system homepage: http://www.cdc.gov/nchs/births.htm Data system phone: 301-458-4111 Agency homepage: http://www.cdc.gov/nchs Agency phone: 301-458-INFO (4636)
References	Ventura, S.J.; Martin, J.A.; Curtin, S.A.; et al. Births: Final Data for 1998. <i>National Vital Statistics Reports</i> 3(Suppl. 48). Hyattsville, MD: National Center for Health Statistics (NCHS), 2000. NCHS. <i>Technical Appendix. Vital Statistics of the United States, 1992</i> . Vol. I, Natality. HHS Pub. No. (PHS) 96-1100. Washington, DC: U.S. Government Printing Office, 1996.

1999 National Worksite Health Promotion Survey (NWHPS)	
Sponsor	Association for Worksite Health Promotion (AWHP), the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (ODPHP), and William M. Mercer, Incorporated.
Mode of Administration	Computer-assisted telephone interview (CATI).
Survey Sample Design	Worksites were defined as an organizational entity comprising 50 or more employees working at a particular geographic location. The sample was drawn randomly from the Dun & Bradstreet universe of employers and classified according to the number of employees at each worksite and Standard Industrial Classification (SIC) code. Size strata were 50-99, 100-249, 250-749, and 750 and more employees. Public sector employers were excluded. Results of the survey were weighted based on the size of the worksite. A total of 1,544 worksites were surveyed in 1998–99.
Response Rates	Overall response rate was 60 percent.
Primary Survey Content	The survey covered employer's health risk and prevention programs and policies provided to their employees; corporate characteristics; corporate perspectives on health, values, support, and barriers; use of health plans for current and future health promotion delivery; delivery mechanisms, cost sharing and incentives; and disease- and demand-management programs and trends.
Population Targeted	Worksites with 50 or more employees, excluding public sector worksites.
Demographic Data	Not applicable.
Years Collected	November 1998–August 1999.
Schedule	Periodic.
Geographic Estimates	National (excluding Alaska and Hawaii).
Notes	There are plans to repeat this survey at least twice between 2001 and 2007 to obtain updates for the Healthy People 2010 objectives that target worksite health promotion programs.
Contact Information	Data system homepage: http://www.awhp.org Data system phone: 847-480-9574 (NWHP) 612-897-8800 (Mercer, Incorporated) Agency homepage: http://odphp.osophs.dhhs.gov Agency phone: 202-205-8611 (ODPHP)
References	Association for Worksite Health Promotion. <i>1999 National Worksite Health Promotion Survey</i> . Northbrook, IL: the Association, 1999.

School Health Policies and Programs Study (SHPPS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
Mode of Administration	State and district level: Self-administered, mailed questionnaire. School and classroom level: On-site, structured personal interview.
Survey Sample Design	For the 1994 SHPPS, all 50 States and the District of Columbia education agencies; a national probability sample of public and private districts; a national sample of public and private middle/junior and senior high school schools, and a random sample of required health education and physical education classes. About 400 districts and 600 schools participated. Respondents included administrators, teachers, school nurses, counselors, food service staff, secretaries, and other school personnel.
Response Rates	For the 1994 SHPPS: State education agencies, 100 percent; school districts, 82 percent; schools, 79 percent; health education teachers, 63 percent; and physical education teachers, 70 percent.
Primary Survey Content	Characteristics (such as policies, administration, planning, program content, program requirements, teaching methodologies, professional preparation of staff, efforts to promote programs, accessibility of services, training needs, etc.) of school health programs, including health education, physical education, food service, health services, and school health policies were measured in 1994.
Population Targeted	Education agencies in all 50 States and the District of Columbia; public and private school districts; public and private middle/junior and senior high schools; required health education and physical education courses.
Demographic Data	For schools, demographic variables include school size, school type, and urbanicity.
Years Collected	1994; 2000.
Schedule	Periodic: Every 6 years.
Geographic Estimates	National estimates for school districts, schools, and health education and physical education courses; State estimates for State education agencies.

School Health Policies and Programs Study (SHPPS)

Notes	SHPPS is the most comprehensive source of national data on policies and programs that support school health programs. SHPPS 2000 is an expanded version of the 1994 SHPPS. About 800 districts and 1,400 schools were asked to participate, including elementary schools. In addition to the 1994 survey content, SHPPS 2000 assesses mental health and social services, faculty and staff health promotion, and family and community involvement. Demographic data will be expanded to include percent of students receiving free or reduced-price school lunches, student-teacher ratios, and race/ethnic distribution of students.
Contact Information	Data system homepage: http://www.cdc.gov/nccdphp/dash/shpps/index.htm Data system phone: 800-231-6405 Agency homepage: http://www.cdc.gov/nccdphp Agency phone: 770-488-5401
References	Errecart, M.T.; Ross, J.G.; Robb, W.; et al. The School Health Policies and Programs Study (SHPPS): Methodology. <i>Journal of School Health</i> 8(65), 1995.

State Tobacco Activities Tracking and Evaluation System (STATE)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Office on Smoking and Health (OSH).
Mode of Administration	The STATE System is a data warehouse. Data are collected and summarized from various sources, including the Behavioral Risk Factor Surveillance System; the Youth Risk Behavior Surveillance System; the Census Bureau, the Economic Research Service, USDA; and SAMHSA. Specifically for Healthy People 2010 objectives, the Lexis-Nexis on-line legal database is used.
Survey Sample Design	Not applicable. Specifically for Healthy People 2010 objectives, CDC, OSH searches two Lexis-Nexis subfiles: the StateTrack System and the Advanced Legislative Services System. Downloads to the STATE database are coded according to variables identified by CDC, OSH.
Response Rates	N/A.
Primary Survey Content	The system contains data on cigarette and other tobacco use, resident population estimates (number of adults and adolescents), the tobacco industry (tobacco agriculture, manufacturing, and cigarette sales), health consequences and cost, State tobacco-control legislation (smokefree indoor air, youth access, preemption, excise tax on tobacco products, licensure, and advertising), and program implementation (cigarette sales to underage persons).
Population Targeted	State tobacco activities.
Demographic Data	Resident population data grouped by adult and youth.
Years Collected	Continuously since 1996. Released on the Internet in May, 1999.
Schedule	Annually for most data sources, quarterly for State tobacco control legislation.
Geographic Estimates	State (see NOTES).

State Tobacco Activities Tracking and Evaluation System (STATE)

Notes	<p>The STATE System is an electronic data warehouse containing up-to-date and historic State-level data on tobacco use prevention and control. It is designed to integrate many data sources to provide comprehensive summary data and facilitate research and consistent interpretation of the data. The STATE System was developed by CDC, NCCDPHP, OSH.</p> <p>National estimates specifically for Healthy People 2010 are derived by summing the State numbers (for example, number of smokefree indoor air policies) across States.</p>
Contact Information	<p>Data system homepage: http://www2.cdc.gov/nccdphp/osh/state/</p> <p>Data system phone: 770-488-5703</p> <p>Agency homepage: http://www.cdc.gov/tobacco</p> <p>Agency phone: 770-488-5701</p>
References	<p>Centers for Disease Control and Prevention (CDC). Tobacco use among middle and high school students, United States, 1999. <i>Morbidity and Mortality Weekly Report</i> 49(03): 49-53, 2000.</p> <p>CDC. Surveillance for selected tobacco use behaviors, United States, 1900–94. <i>Morbidity and Mortality Weekly Report</i> 43(SS-3):49-53, 1994.</p> <p>CDC. Attitudes toward smoking policies in eight States, United States, 1993. <i>Morbidity and Mortality Weekly Report</i> 43(43): 786-789, 1994.</p>

STD Surveillance System (STDSS)

Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention (NCHSTP).
Mode of Administration	Reports from health care providers are sent to the local/State/territorial health departments.
Survey Sample Design	All 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and 64 select large cities report STD cases.
Response Rates	Response rates vary by disease and patient population. Estimates of completeness for case reporting of syphilis, gonorrhea, and chlamydia are 65, 50, and 20 percent, respectively.
Primary Survey Content	Summary case count data are submitted monthly, quarterly, and annually using OMB-approved hard copy forms. Hard copy reporting is being replaced by electronic line-listed data. Currently, electronic line-listed data are submitted by more than half of the reporting States. Disease-specific information and demographics are available.
Population Targeted	Health care providers and laboratories providing medical care and laboratory services to persons with STDs.
Demographic Data	Age, gender, race, ethnicity, State and county of residence, country of birth.
Years Collected	CDC first provided reports of persons with STDs in 1941.
Schedule	Annual. STD Surveillance Report is published annually and is supplemented by the Chlamydia Prevalence Monitoring Annual Report, the Gonococcal Isolate Surveillance Project (GISP) Annual Report, and the Syphilis Surveillance Report. Report is available on the Web at http://www.cdc.gov/wonder/STD/Contents.shtml .
Geographic Estimates	National, State, regional, and selected large cities and counties. Data release policies dictate that no data that could be used to identify a person reported to the system may be released; thus, release of data in cell sizes less than or equal to five in a given category is prohibited.

STD Surveillance System (STDSS)

Contact Information	Data system homepage: http://www.cdc.gov/nchstp/dstd/Stats_Trends/Stats_and_Trends.htm Data system phone: 404-639-8356 Agency homepage: http://www.cdc.gov/nchstp/od/nchstp.html Agency phone: 404-639-2070
References	Centers for Disease Control and Prevention (CDC), Division of Sexually Transmitted Disease Prevention. <i>Sexually Transmitted Disease Prevention Surveillance</i> . Atlanta, GA: CDC, 1999. CDC. Case definition for infectious conditions under public health surveillance. <i>Morbidity and Mortality Weekly Report</i> 46(RR10), 1997. CDC. Guidelines for evaluating surveillance systems. <i>Morbidity and Mortality Weekly Report</i> 37(S5), 1988.

United States Renal Data System (USRDS)

Sponsor	U.S. Department of Health and Human Services, National Institutes for Health (NIH), National Institute for Diabetes and Digestive and Kidney Disease (NIDDK) in collaboration with the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).
Mode of Administration	Continuous mandated reporting from physicians who treat end-stage renal disease (ESRD).
Survey Sample Design	The database consists of patient and facility records from the HCFA ESRD Program Management and Medical Information System, the Annual Facility Survey, and data on transplant followup and Medicare parts A and B services derived from Medicare claims. These HCFA-supplied data are supplemented by data from the Social Security Administration, the U.S. Department of Veterans Affairs facilities, the U.S. Census Bureau, local and national ESRD provider databases, and international ESRD registries. Patient-specific data are compiled from medical records, as well as data on medical providers and treatment facilities. Special studies utilize random samples of patient population medical records.
Response Rates	About 96 percent of all treated ESRD patients in the United States are covered.
Primary Survey Content	Date of onset of ESRD, treatment modality (including dialysis and kidney transplantation), causes of death, patient survival, hospitalization, cost and cost effectiveness, and institutional providers of ESRD treatment. Questions in special surveys cover behavioral risk factors (for example, alcohol and tobacco use), preventive health measures, health status, limitation of activity, and health care access and utilization.
Population Targeted	Medicare and non-Medicare ESRD patients. The USRDS contains data on approximately 1 million patients treated between 1977 and 1998.
Demographic Data	Gender, age, income, education, race, Hispanic ethnicity (available since April 1995).
Years Collected	Continuously since 1988.
Schedule	Annual.
Geographic Estimates	National, State, and county.

United States Renal Data System (USRDS)

Notes	The USRDS provides data on the incidence, prevalence, mortality rates, and trends over time of end-stage renal disease by primary diagnosis, treatment modality, and sociodemographic variables. Data are published in an Annual Data Report, which is available on the Internet at http://www.med.umich.edu/usrds . Other data collected by the database include services resources; services utilization; and services expenditures and financing.
Contact Information	Data system homepage: http://www.usrds.org Survey description: http://www.os.dhhs.gov/progorg/aspe/minority/minnih9.htm Agency homepage: http://www.niddk.nih.gov Agency phone: 301-594-1932
References	U.S. Renal Data System (USRDS). <i>1999 Annual Data Report</i> . Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Published annually.

Youth Risk Behavior Surveillance System (YRBSS)							
Sponsor	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).						
Mode of Administration	School based; administered in classrooms by professional survey administrators. Anonymous self-administered questionnaires. Make-up surveys conducted for absentees.						
Survey Sample Design	The YRBSS has several components all of which are administered among samples of 9th through 12th grade students: a national survey, State surveys administered by the States, local surveys administered by 16 of the largest cities, a survey of the Navaho Indian Nation schools, and a census of Bureau of Indian Affairs schools. The national survey uses a three-stage probability sample. It is completed biennially by students in about 150 public and private schools, grades 9-12. African-American and Hispanic/Latino students are over-sampled in the national survey. In the 1999 national survey, N= 15,349; grade 9 = 28.9 percent; grade 10 = 26.0 percent; grade 11 = 23.6 percent; and grade 12 = 21.4 percent.						
Response Rates	<p><u>For 1999:</u></p> <table> <tr> <td>School response rate</td> <td>77%</td> </tr> <tr> <td>Individual response rate</td> <td>86%</td> </tr> <tr> <td>Overall response rate</td> <td>66%</td> </tr> </table>	School response rate	77%	Individual response rate	86%	Overall response rate	66%
School response rate	77%						
Individual response rate	86%						
Overall response rate	66%						
Primary Survey Content	Six categories of health risk behaviors: injury, tobacco use, alcohol and other drug use, sexual behavior, diet and nutrition, and physical activity.						
Population Targeted	Students in grades 9-12.						
Demographic Data	<p>Gender, age, grade, race/ethnicity, urbanicity of school.</p> <p>Race/ethnicity data are collected using a single question. Categories are White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, Hispanic or Latino. Respondents can choose one or more categories. Persons who select "Hispanic or Latino" are only counted as Hispanic or Latino, whereas people who select multiple race categories (not including Hispanic or Latino) are classified as "multiracial." (The number in the multiracial category is very small.) When the data are compiled, persons who select White only are classified as nonHispanic White. Person who select Black or African American only are classified as non-Hispanic Black or African American.</p>						

Youth Risk Behavior Surveillance System (YRBSS)

Years Collected	1990; biennially since 1991.
Schedule	Biennial (odd-numbered years).
Geographic Estimates	National survey: national and four U.S. Census Bureau regions; State survey: 41 States and the District of Columbia in 1999; Local survey: 16 selected large urban school districts in 1999.
Notes	This is one of the few school-based surveys that conducts a makeup survey for students who are absent during the original survey yielding excellent coverage of the in-school youth population. Other components of the YRBSS include a national alternative school survey, middle school surveys in selected States, and the National College Health Risk Behavior Survey. For the 1999 YRBSS, questionnaire revisions were made to be responsive to the Healthy People 2010 objectives and current trends.
Contact Information	Data system homepage: http://www.cdc.gov/nccdphp/dash/yrbs/ov.htm Data system phone: 800-231-6405 Agency homepage: http://www.cdc.gov/nccdphp Agency phone: 770-488-5401
References	Kann, L.; Kichen, S.A.; Williams, B.I.; et al. Youth risk behavior surveillance, United States. <i>Morbidity and Mortality Weekly Report Surveillance Summary</i> 47(SS-3):1-89, 1997. Kann, L.; Warren, C.W.; Harris, W.A.; et al. Youth risk behavior surveillance, United States. <i>Morbidity and Mortality Weekly Report Surveillance Summary</i> 45(SS-4):1-83, 1995. Kann, L.; Kolbe, L.J.; and Collins, J.L. (eds). Measuring the health behavior of adolescents: The Youth Risk Behavior Surveillance System and recent reports on high-risk adolescents. <i>Public Health Reports</i> 108 (Suppl. 1), 1993.