2022 National Healthcare Quality and Disparities Report Data Sources

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CONTENTS

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Healthcare Cost and Utilization Project (HCUP)

Sponsor

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ)

Description

The Healthcare Cost and Utilization Project (HCUP) databases bring together the data collection efforts of state data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of discharge-level healthcare data.

HCUP includes a collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to healthcare programs, and outcomes of treatments at the national, state, and local market levels.

Four HCUP discharge datasets were used in this report:

1. The HCUP State Inpatient Databases (SID) include a powerful set of hospital databases from HCUP Partner organizations in 47 states and the District of Columbia. Together, the SID encompasses about 97% of all U.S. community hospital discharges. SID contains a core set of clinical and nonclinical information on all patients, regardless of payer, including people covered by Medicare, Medicaid, and private insurance, as well as those who are self-pay or no charge. In addition to the core set of uniform data elements common to all of the SID, some states report other data elements, such as patient race.
2. Two versions of the nationally weighted NHQDR analysis file were used for reporting national QI estimates under ICD-10-CM/PCS. Both used the SID, but were limited to community hospitals, excluding rehabilitation and long-term acute care (LTAC) facilities. The two versions were specific to the data elements needed for the different QI modules. For the PQIs, IQIs, and area-based PDIs, the nationally weighted file included data from SID that included information on race/ethnicity of the patient. After hospitals that failed the race/ethnicity edits were excluded, all remaining discharges in the selected SID were weighted to the universe of community hospitals in the United States, excluding rehabilitation and LTAC facilities.

   Because the PSIs and related PDIs require knowing if the patient safety event occurred in the hospital and the timing of procedures, a second version of the nationally weighted file was created using the following criteria: (1) the SID included the data elements indicating diagnoses were POA, (2) the SID included information on day of principal and secondary procedure days, and (3) the SID included information on the race/ethnicity of the patient. Hospitals in qualifying SID were excluded if they failed POA and race/ethnicity edits.

All remaining discharges were weighted to the universe of community hospitals in the United States, excluding rehabilitation and LTAC facilities. In 2019, 42 states were included in the subset of QIs that required POA reporting, and 48 states were included in the subset of QIs that did not require POA reporting.

3. The HCUP National Inpatient Sample (NIS) is drawn from all states participating in HCUP, covering more than 97% of the U.S. population. The NIS approximates a 20% stratified sample of discharges from U.S. community hospitals, excluding rehabilitation and long-term acute care hospitals. The large sample size in the enables analyses of rare conditions, uncommon treatments, and special patient populations. The 2019 NIS includes inpatient data from 47 states plus the District of Columbia.
4. The Nationwide Emergency Department Sample (NEDS) was constructed using the HCUP State Emergency Department Databases (SEDD) and the SID. The SEDD captures encounter information on emergency department (ED) visits that do not result in an admission (i.e., treat-and-release visits and transfers to another hospital). The SID contains information on patients initially seen in the ED and then admitted to the same hospital. The NEDS was created to enable analyses of ED utilization patterns and is the largest all-payer ED database that is publicly available in the United States.

   The NEDS is a 20% stratified sample of hospital-owned EDs in the United States. Forty states and the District of Columbia contributed data to the 2019 NEDS: AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY. These states are geographically dispersed and account for 82.8% of the total U.S. resident population and 82.2% of all U.S. ED visits.

Primary Content

The HCUP NIS, NEDS, and SID contain more than 100 clinical and nonclinical data variables, including age, sex, patient race/ethnicity, diagnoses, procedures, length of stay, discharge status, expected source of payment, total charges, hospital size, ownership, region, and teaching status. The HCUP databases combine categories for patient race/ethnicity categories, resulting in the following subgroups: Hispanic of all races, and non-Hispanic African Americans, Asians and Pacific Islanders, and Whites. Not all states uniformly collect race and ethnicity data; when a state and its hospitals collect Hispanic ethnicity separately from race, HCUP uses Hispanic ethnicity to override any other race category.

Many of the NHQDR measures that use HCUP data are based on AHRQ Quality Indicators (QIs) Software v2020.1, a set of algorithms that may be applied to hospital administrative data to quantify quality issues among inpatient populations. The QIs fall into four categories:

1. Inpatient Quality Indicators (IQIs) reflect quality of care in hospitals and currently include 19 mortality indicators for conditions or procedures and indicators for 6 procedures for which outcomes may be related to the volume of procedures are included in the IQIs.
2. Prevention Quality Indicators (PQIs) assess hospital admissions for 13 ambulatory care-sensitive conditions, that evidence suggests may be avoided, in part, through high-quality ambulatory care. PQI software v2020.1 also includes 4 composite measures assessing

potentially avoidable hospitalizations overall, for acute conditions, for chronic conditions, and for diabetes-specific conditions.
3. Patient Safety Indicators (PSIs) reflect potential inpatient complications and other patient safety concerns following surgeries, other procedures, and childbirth. PSI software v2020.1 has 18 measures.
4. Pediatric Quality Indicators (PDIs) examine 16 conditions that pediatric patients experience within the healthcare system that may be preventable by changes at the system or provider level. PQI software v2020.1 includes 3 composite measures assessing hospitalizations overall, for acute conditions, and for chronic conditions. In earlier versions of the QI software, some PDI measures were part of the IQI, PSI, and PQI modules.

For reporting in 2019, we applied the QI software to the HCUP databases without modification. Rates prior to 2016 are not reported because of the transition to the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System. Risk-adjusted rates for all applicable QIs are provided.

Population Targeted

The population targeted by HCUP databases includes any person, U.S. citizen or foreign, using nonfederal, nonrehabilitation, community hospitals in the United States as defined by AHA. AHA defines community hospitals as "all nonfederal, short-term, general, and other specialty hospitals, whose facilities and services are available to the public" (Health Forum, LLC ©2017)." Included among community hospitals are specialty hospitals, such as obstetrics-gynecology, ear-nose-throat, short-term rehabilitation, orthopedic, and pediatric institutions. Also included are public hospitals and academic medical centers.

The NIS and analyses of the SID for this report excluded short-term rehabilitation hospitals, long-term acute-care hospitals, psychiatric hospitals, and alcoholism/chemical dependency treatment facilities.

Although not all states participate in the HCUP database, the NIS, the NEDS, and the nationally weighted analysis files are weighted to give national estimates of all U.S. community hospitals, excluding rehabilitation and long-term, acute-care hospitals, as identified by the AHA Annual Survey (Health Forum, LLC © 2017).

Demographic Data

Age, sex, race/ethnicity, expected primary payer, median household income of the patient's ZIP Code, urbanized location, and region of the United States

Years Collected

Since 1988

Data Collection Schedule

Annual

Geographic Estimates

National, four U.S. Census Bureau regions, states (for states participating in SID that agree to the release)

Notes

Sources of HCUP Data

- **Alaska** Department of Health and Social Services
- **Alaska** State Hospital and Nursing Home Association
- **Arizona** Department of Health Services
- **Arkansas** Department of Health
- **California** Office of Statewide Health Planning and Development
- **Colorado** Hospital Association
- **Connecticut** Hospital Association
- **Delaware** Division of Public Health
- **District of Columbia** Hospital Association
- **Florida** Agency for Health Care Administration
- **Georgia** Hospital Association
- **Hawaii** Laulima Data Alliance
- **Hawaii** University of Hawai'i at Hilo
- **Illinois** Department of Public Health
- **Indiana** Hospital Association
- **Iowa** Hospital Association
- **Kansas** Hospital Association
- **Kentucky** Cabinet for Health and Family Services
- **Louisiana** Department of Health
- **Maine** Health Data Organization
- **Maryland** Health Services Cost Review Commission
- **Massachusetts** Center for Health Information and Analysis
- **Michigan** Health & Hospital Association
- **Minnesota** Hospital Association
- **Mississippi** State Department of Health
- **Missouri** Hospital Industry Data Institute
- **Montana** Hospital Association
- **Nebraska** Hospital Association
- **Nevada** Department of Health and Human Services
- **New Hampshire** Department of Health & Human Services
- **New Jersey** Department of Health
- **New Mexico** Department of Health
- **New York** State Department of Health
- **North Carolina** Department of Health and Human Services
- **North Dakota** (data provided by the Minnesota Hospital Association)
- **Ohio** Hospital Association
- **Oklahoma** State Department of Health

- **Oregon** Association of Hospitals and Health Systems
- **Oregon** Office of Health Analytics
- **Pennsylvania** Health Care Cost Containment Council
- **Rhode Island** Department of Health
- **South Carolina** Revenue and Fiscal Affairs Office
- **South Dakota** Association of Healthcare Organizations
- **Tennessee** Hospital Association
- **Texas** Department of State Health Services
- **Utah** Department of Health
- **Vermont** Association of Hospitals and Health Systems
- **Virginia** Health Information
- **Washington** State Department of Health
- **West Virginia** Department of Health and Human Resources, West Virginia Health Care Authority
- **Wisconsin** Department of Health Services
- **Wyoming** Hospital Association

For reporting in 2018, we applied the QI software to the HCUP databases without modification. Rates prior to 2016 are not reported because of the transition to the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System. Risk-adjusted rates for all applicable QIs are provided.

Contact Information

Agency home page: http://www.ahrq.gov. Accessed October 20, 2022.
Data system home page: https://www.ahrq.gov/data/hcup/index.html. Accessed October 20, 2022.
AHRQ Quality Indicators: https://qualityindicators.ahrq.gov/. Accessed October 20, 2022.

References

Barrett M, McCarty J, Kenney T, Liang L. Methods Applying AHRQ Quality Indicators to Healthcare Cost and Utilization Project (HCUP) Data for the 2021 National Healthcare Quality and Disparities Report (NHQDR). 2021. HCUP Methods Series Report. U.S. Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/reports/methods/methods.jsp. Accessed October 20, 2022.

Agency for Healthcare Research and Quality. Inpatient Quality Indicators: Technical Specifications, AHRQ Quality Indicators, v2020.1 SAS. Rockville, MD: Agency for Healthcare Research and Quality; May 2020.

Agency for Healthcare Research and Quality. Patient Safety Indicators: Technical Specifications, AHRQ Quality Indicators, v2020.1 SAS. Rockville, MD: Agency for Healthcare Research and Quality; May 2020.

Agency for Healthcare Research and Quality. Pediatric Quality Indicators: Technical Specifications, AHRQ Quality Indicators, v2020.1 SAS. Rockville, MD: Agency for Healthcare Research and Quality; May 2020.

Agency for Healthcare Research and Quality. Prevention Quality Indicators: Technical Specifications, AHRQ Quality Indicators, v2020.1 SAS. Rockville, MD: Agency for Healthcare Research and Quality; May 2020.

For detailed information about QI measures, refer to the individual guides to the quality indicators listed below, available from the archives at https://qualityindicators.ahrq.gov/. Accessed October 20, 2022.

National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database

Sponsor

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) in association with a consortium of public and private organizations

Description

Health plan members report on their experiences and rate their health plans and providers in several areas by responding to a standardized set of questions administered through a mail or telephone questionnaire. Participation in the CAHPS Database is voluntary.

Survey Sample Design

CAHPS surveys are administered to a random sample of health plan members by independent survey vendors, following standardized procedures. Since 1998, health plans, purchaser groups, state organizations and others have participated in this component.

The CAHPS sampling recommendation is to achieve a minimum of 300 completed responses per health plan, with a target response rate of 50%. The plan samples are not adjusted for unequal probabilities of selection. This logic stems from the principle that the precision of the estimates depends primarily on the size of the sample and not on the size of the population from which it is drawn. Therefore, the given sample size will give the same precision for means or rates regardless of the overall size of the population.

Primary Survey Content

The 5.0 version of the CAHPS Adult and Child Health Plan Surveys reporting questions fall into four major “composite measures” that summarize consumer experiences in the following areas: getting needed care, getting care quickly, how well doctors communicate, and health plan information and customer service.

Population Targeted

CAHPS surveys target several different populations, such as adults, children, children with chronic conditions, and beneficiaries of Medicaid, Medicare and/or Medicare managed care, and other public plans.

Estimates for tables based on Medicaid CAHPS (Adult and Child) data were calculated using plan weights, i.e., all respondents in a plan received the same weight.

Demographic Data

State

Years Collected

Since 1998

Data Collection Schedule

Annual

Geographic Estimates

State

Notes

The CAHPS Health Plan Survey Database was also referred to as the CAHPS Database, formerly known as the National CAHPS Benchmarking Database (NCBD).

The 5.0 Medicare Managed Care data are obtained from the Centers for Medicare & Medicaid Services (CMS) for survey participants; however, in 2020, CMS did not report Medicare and FFS data due to the COVID-19 pandemic. Therefore, results are not included in the 2020 CAHPS Health Plan Survey Results for the NHQDR.

The 5.0 Medicaid data were obtained from data submitted directly to the CAHPS Database by state Medicaid agencies and individual health plans.

The look-back period of Medicare patients' experience was changed from "last 12 months" to "last 6 months" in 2018. To reflect this change, NHQDR measure titles were edited from "in the last 12 months" to "in the last 6 or 12 months."

Contact Information

Agency home page: https://www.ahrq.gov/CAHPS. Accessed October 20, 2022.

References

The CAHPS Database, 2020 CAHPS Health Plan Survey Database, 2020 Chartbook: What Consumers Say About Their Experiences With Their Health Plans and Medical Care available from https://cahpsdatabase.ahrq.gov/files/2020CAHPSHealthPlanChartbook.pdf. Accessed October 20, 2022.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Behavioral Risk Factor Surveillance System (BRFSS)

Sponsor

Currently, there is a wide sponsorship of the BRFSS survey, including most divisions in the CDC National Center for Chronic Disease Prevention and Health Promotion; other CDC centers; and federal agencies, such as the Health Resources and Services Administration, Administration on Aging, Department of Veterans Affairs, and Substance Abuse and Mental Health Services Administration.

Description

BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and 3 U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Survey Sample Design

BRFSS is a state-based system of telephone health surveys of noninstitutionalized adults age 18 and over who reside in households. The BRFSS is conducted by landline and cell phone. Random-digit-dialed (RDD) probability design was used initially. Disproportionate stratified sample (DSS) design has been implemented for landline portions of the sample since 2003 and the number of states using DSS is increasing. In the DSS design most commonly used in the BRFSS, telephone numbers are divided into two strata, high density and medium density. Strata are sampled separately. Telephone numbers in the high-density stratum are sampled at the highest rate. In 2011, 50 states and the District of Columbia used DSS design. Guam, Puerto Rico, and the U.S. Virgin Islands used RDD design.

BRFSS piloted the Cell Phone Survey beginning in 2008. By including cell phones in the survey, BRFSS can reach segments of the population that were previously inaccessible—those who have a cell phone but not a landline—and produce a more representative sample and higher quality data.

Cell Phone surveys were included in the public release dataset beginning in 2011. A second important change in 2011 was the move to a new weighting system (ranking) that incorporates cell phone data and includes new variables (education, marital status, and home ownership) as controls.

As BRFSS moves to incorporating cell phone data and changing weighting methods, a review of reliability and validity research indicated that past BRFSS landline-only data were reliable and valid as measured against other surveys. New analyses and comparisons of BRFSS data that include the new methodologies and cell phone data will be needed to ascertain the impact of these changes on estimates in the future. The 2003-2016 NHQR/DR only used the BRFSS landline data collected before 2011.

Primary Survey Content

The objective of the BRFSS is to collect uniform, state-specific data on preventive health practices and risk behaviors linked to chronic diseases, injuries, and preventable infectious diseases in the adult population.

The survey consists of core questions asked in all states, standardized optional questions on selected topics administered at the state's discretion, a rotating set of core questions asked every other year in all states, and state-added questions developed to address state-specific needs. Questions cover behavioral risk factors (e.g., alcohol and tobacco use), preventive health measures, HIV/AIDS, health status, activity limitations, and healthcare access and utilization.

Population Targeted

U.S. civilian noninstitutionalized population, age 18 and over who, reside in households

Demographic Data

Gender, age, educational attainment, race/ethnicity, household income, employment status, and marital status

Years Collected

Since 1984

Data Collection Schedule

Data are collected monthly, and results are distributed annually.

Geographic Estimates

National; state; smaller area estimates in some states

Notes

The number of states participating in the survey has increased from 15 in 1984 to 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands since 2001.

Contact Information

Agency home page: https://www.cdc.gov. Accessed October 20, 2022.
Data system home page: https://www.cdc.gov/brfss. Accessed October 20, 2022.

References

Centers for Disease Control and Prevention. The BRFSS Data User Guide. Atlanta, GA: U.S. Department of Health and Human Services; August 15, 2013, https://www.cdc.gov/brfss/data_documentation/pdf/UserguideJune2013.pdf. Accessed October 20, 2022.

Go to https://www.cdc.gov/brfss/data_documentation/index.htm (accessed October 20, 2022) for a collection of documents and survey data providing technical and statistical information regarding BRFSS, such as comparability and sampling information.

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)

Description

NAMCS is a national survey designed to meet the need for objective, reliable information about the provision and use of ambulatory medical care services in the United States. Findings are based on a sample of visits to non-federally employed office-based physicians who are primarily engaged in direct patient care. The survey excludes physicians in the specialties (including designated subspecialties) of anesthesiology, pathology, and radiology.

Survey Sample Design

The survey was conducted annually from 1973 to 1981 and again in 1985. It has been fielded annually since 1989. The sampling frame for office-based physicians in NAMCS is derived from the American Medical Association and the American Osteopathic Association master files. Physicians are excluded if they are federally employed, do not provide direct patient care, or specialize in anesthesiology, radiology, or pathology. A special stratum of health center providers was first added in 2006.

The sampling frame for health center providers in NAMCS is developed using data from the Health Resources and Services Administration's Bureau of Primary Health Care Uniform Data System and the Indian Health Service. Each participating health center provides a list of physicians and midlevel providers who would be available during the predetermined 1-week reporting period. This list becomes the frame for selection of up to three physicians and midlevel providers in each health center.

To maintain consistency with measures included before 2006, this report excludes visits to health center midlevel providers. Before 2012, NAMCS relied on paper instruments; the survey switched to computerized data collection in 2012. Each physician is randomly assigned to a 1-week reporting period. Data about the physician and their practice characteristics are collected during a survey induction interview.

Primary Survey Content

Data are collected from medical records and include type of provider seen; reason for visit; diagnoses; drugs ordered, provided, or continued; and selected procedures and tests ordered or performed during the visit. Patient data include age, sex, race, and expected source of payment. Data are also collected on selected characteristics of physician practices.

Population Targeted

Sample data are weighted to produce national estimates of office visits. The basic sampling unit is the patient visit. The specialties of anesthesiology, pathology, and radiology are not included. Also 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.

Demographic Data

Patient's age, gender, race/ ethnicity, and location of residence

Years Collected

Annually from 1973-1981; 1985; an annual schedule was resumed in 1989

Data Collection Schedule

Annual

Geographic Estimates

National; U.S. Census Bureau regions

Notes

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

Agency home page: http://www.cdc.gov/nchs/. Accessed September 13, 2022.
Data system home page: http://www.cdc.gov/nchs/ahcd.htm. Accessed September 13, 2022.

References

National Ambulatory Medical Care Survey 2010 Summary Tables. http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf. Accessed September 13, 2022.

National Ambulatory Medical Care Survey, 2018 NAMCS Micro-data File Documentation. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc2018-508.pdf. Accessed September 13, 2022.

National Electronic Health Records Survey (NEHRS)

Sponsor

NEHRS is sponsored by the Office of the National Coordinator for Health Information Technology (ONC) and conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services.

Description

The NEHRS is an annual source of information on the adoption and use of electronic health record (EHR) systems by office-based physicians and their practices in the United States (excluding those in the specialties of anesthesiology, radiology, and pathology). Results from NEHRS have been instrumental in providing data to track adoption and use of EHR systems, and progress physicians have made toward meeting the policy goals of the HITECH Act. In more recent years, survey data have been used to measure the sharing of patient health information,

and participation in the Promoting Interoperability programs, sponsored by the Centers for Medicare & Medicaid Services (CMS).

Survey Sample Design

NEHRS began in 2008 and was originally designed as an annual mail supplement to the National Ambulatory Medical Care Survey (NAMCS). Starting in 2010, funding permitted an increase in the sample size to allow measurement of EHR adoption rates by all 50 U.S. states and the District of Columbia. Since 2012, NEHRS has been administered as a survey independent of NAMCS, using data collection through web, postal mail, and telephone.

Primary Survey Content

The survey collects information about basic computerized capacities, safety, patient engagement, population management, payment systems, and information exchanges.

Population Targeted

Office-based physicians and their practices in the United States (excluding those in the specialties of anesthesiology, radiology, and pathology)

Demographic Data

Physician's age and specialty, practice size, ownership, region, non-Hispanic White population, and metropolitan status of the practice

Years Collected

Annually from 2010

Data Collection Schedule

Annual

Geographic Estimates

National and state

Notes

Detailed information is available in the NEHRS questionnaire, https://www.cdc.gov/nchs/data/nehrs/2018_NEHRS_Questionnaire_08092018-508.pdf. Accessed October 20, 2022.

Contact Information

Agency home page: http://www.cdc.gov/nchs/. Accessed October 20, 2022.
Data system home page: https://www.cdc.gov/nchs/nehrs/about.htm. Accessed October 20, 2022.

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)

Description

NHANES is a nationally representative survey of the resident civilian noninstitutionalized U.S. population. It consists of questionnaires administered in the home followed by a standardized physical examination in specially equipped mobile examination centers (MECs). The examination includes physical measurements, such as blood pressure and dental examinations, and collection of blood and urine specimens for laboratory testing.

Survey Sample Design

A complex, multistage, probability sampling design is used to select a sample representative of the civilian, noninstitutionalized household population of the United States. The four stages of sampling are: first, the primary sampling units (i.e., mostly counties); second, segments within counties; third, dwelling units / households; and fourth, individuals within a household.

Since 1999, NHANES has continuously collected health data from across the nation, with public use data released in 2-year cycles. Data collection for the 2019-2020 cycle was suspended in March 2020 due to safety concerns from the COVID-19 public health emergency and was not rescheduled for the remaining sites in 2020. Therefore, the 2019-March 2020 data were not nationally representative and would not yield meaningful standalone estimates.

In addition, the 2019-March 2020 data were drawn from a 2019-2022 sample design, and the sample selected for 2021-2022 data collection based on that sample design was also dropped. For more information, refer to the sample design and analytic guidelines at http://www.cdc.gov/nchs/data/series/sr_02/sr02-190.pdf.

Primary Survey Content

Data collected include information on chronic diseases (including undiagnosed conditions) and health status, dietary intake and nutritional status, infectious disease and immunization status, environmental health and exposures, and related risk factors. The risk factors include smoking, alcohol consumption, sexual practices, drug use, physical fitness and activity, weight, and dietary intake. Data on certain aspects of reproductive health, such as use of oral contraceptives and breastfeeding practices, are also collected. Specific survey content may vary by survey cycle.

Population Targeted

NHANES samples the noninstitutionalized civilian resident population of the United States. NHANES excludes all people in supervised care or custody in institutional settings, all active-duty military personnel, active-duty family members living overseas, and any other people residing outside the 50 United States and the District of Columbia. Beginning in 1999, NHANES has included people of all ages.

Demographic Data

Gender, age, race and Hispanic origin, educational level, place of birth, income, and occupation

Years Collected

From 1959 to 1962 (National Health Examination Survey [NHES] I), 1963-1965 (NHES II), 1966-1970 (NHES III), 1971-1974 (NHANES I), 1976-1980 (NHANES II), 1982-1984

(Hispanic Health and Nutrition Examination Survey), 1988-1994 (NHANES III), 1999-March 2020 (NHANES)

Data Collection Schedule

Fielded periodically (1960-1994); annually beginning in 1999, with data releases occurring in 2-year cycles.

Geographic Estimates

National; four U.S. Census Bureau regions (from 1988).

Notes

To get reliable estimates, pooled data were used for the NHQDR.

Contact Information

Agency home page: http://www.cdc.gov/nchs. Accessed September 13, 2022.
Data system home page: http://www.cdc.gov/nchs/nhanes.htm. Accessed September 13, 2022.

References

Ezzati TM, Massey JT, Waksberg J, et al. Sample design: Third National Health and Nutrition Examination Survey. Vital Health Stat 1992; 2(113).

National Center for Health Statistics. Plan and operation of the Third National Health and Nutrition Examination Survey, 1988–94. Vital Health Stat 1994; 1(32).

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)

Description

The National Health Interview Survey (NHIS) monitors the health of the U.S. population through the collection and analysis of data on a broad range of health topics. The survey covers the civilian noninstitutionalized population residing in the United States at the time of the interview. Black, Hispanic, and Asian people are oversampled. The questionnaire has core questions and supplements. Core questions remain largely unchanged from year to year and allow trend analysis and pooling of data from more than one year to increase sample size for analytic purposes.

The core contains four major components: Household, Family, Sample Adult, and Sample Child. The Household component collects limited demographic information on all of the individuals living in a particular house. The Family component verifies and collects additional demographic information on each member from each family in the house and collects data on topics including health status and limitations, injuries, healthcare access and utilization, health insurance, and income and assets. Since the 2019 redesign, much of the content that was collected in the family

section is collected directly within the sample adult and sample child questionnaires. The supplements are used to respond to new public health data needs as they arise.

The questionnaires are sometimes fielded only once or are repeated as needed. These questionnaires may be used to provide additional detail on a subject already covered in the core or on a different topic not covered in other parts of NHIS.

Survey Sample Design

NHIS is a cross-sectional household interview survey. Sampling and interviewing are continuous throughout each year. The sampling plan follows an area probability design that permits the representative sampling of households and noninstitutional group quarters (e.g., college dormitories). The sampling plan is redesigned after every decennial census. The sample size for the sample design starting in 2016 (and similar to the sample design coving 2006-2015) is about 35,000 households containing about 27,000 sample adults and 9,000 children.

Clusters of addresses were defined within each state; the sizes of the clusters correspond generally to the size of an interviewer's workload over the course of the sample design period. Each cluster is located entirely within a county, a small group of contiguous counties, or a metropolitan statistical area. The sampling plan is a sample of these clusters of addresses.

A redesigned NHIS questionnaire was filed in 2019, the first significant questionnaire redesign since 1997. The content and structure of NHIS were updated in 2019 to better meet the needs of data users. Aims of the questionnaire redesign were to improve the measurement of covered health topics, reduce respondent burden by shortening the length of the questionnaire, harmonize overlapping content with other federal health surveys, establish a long-term structure of ongoing and periodic topics, and incorporate advances in survey methodology and measurement. Detailed information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm (accessed September 13, 2022).

The NHIS weighting procedures were updated in 2019, partly because the response rates have been steadily declining from roughly 92% in 1997 to 61.1% in 2019.

Primary Survey Content

After household composition is established, the core family interview asks about everyone in each family within 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 activity limitations, health behaviors, healthcare access, healthcare provider contacts and immunizations. The sample child questionnaire includes questions about chronic health conditions, activity limitations, health status, behavior problems, healthcare access and use, and immunizations.

Child data are proxy reported by a parent or other knowledgeable adult respondent. Adult sample person data are self-reported, except in limited cases where a physical or mental impairment prevents some adults from answering questions themselves. Supplemental modules are fielded periodically and cover areas such as cancer, prevention, disability, and use of complementary and alternative medicine.

Population Targeted

Civilian noninstitutionalized population residing in the United States

Demographic Data

Gender, age, race/ethnicity, education, income, marital status, place of birth, industry, and occupation

Years Collected

Continuously, since 1957.

Data Collection Schedule

Annually

Geographic Estimates

National; U.S. Census Bureau regions; some of the 10 Health and Human Services regions; some states; metropolitan and nonmetropolitan areas

Notes

Metropolitan statistical areas are based on the Office of Management and Budget (OMB) standards for defining metropolitan and micropolitan areas.

- Metropolitan counties include:
  - Large Central - Central counties in metro areas of 1 million or more population
  - Large Fringe - Outlying counties in metro areas of 1 million or more population
  - Medium - Counties in metro areas of 250,000-999,999 population
  - Small - Counties in metro areas of 50,000-249,999 population
- Nonmetropolitan counties include:
  - Micropolitan - Counties in areas with an urban cluster of 10,000-49,999 population
  - Noncore – Nonmicropolitan

The 2000-2015 NHIS estimates for the 2003-2017 NHQDR used the 2006 NCHS metropolitan statistical areas file, which was based on the 2000 OMB standards and on the 2000 census.

Since the 2018 NHQDR, NHIS estimates have used the 2013 NCHS metropolitan statistical areas file, which was based on the 2013 OMB standards and on Vintage 2012 postcensal estimates of the resident U.S. population.

For details, the NCHS Urban-Rural Classification Schemes for Counties are available at https://www.census.gov/programs-surveys/metro-micro.html (accessed September 13, 2022) and https://www.cdc.gov/nchs/data_access/urban_rural.htm (accessed September 13, 2022).

Adults with a disability is redefined beginning with 2019 data based on the methodology of the American Community Survey. Adults age 18 and over are defined as with disability if they report any serious difficulty in hearing, serious difficulty in vision, serious cognitive difficulty, serious difficulty in walking or claiming stairs, difficulty in dressing or bathing, or difficulty in

doing errands. Adults are defined as without disability if they report not having any of the serious difficulties.

Due to the 2019 questionnaire redesign, estimates from 2019 are not comparable with earlier years' data. Measures with 2019 or later data are included in the NHQDR disparities analysis but are excluded from trend analysis.

The 2020 NHIS data collection switched to a telephone-only mode beginning March 19, 2020. Personal visits resumed in all areas in September 2020, but cases were still attempted by telephone first. These changes resulted in lower response rates and differences in respondent characteristics for April-December 2020. Differences observed in estimates between April and December 2020 and earlier time periods may still be affected by these changes.

Contact Information

Agency home page: https://www.cdc.gov/nchs. Accessed September 13, 2022.
Data system home page: https://www.cdc.gov/nchs/nhis.htm. Accessed September 13, 2022.

References

For more details, refer to https://www.cdc.gov/nchs/nhis/about_nhis.htm (accessed September 13, 2022) and the datasets and documentation section at https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm (accessed September 13, 2022).

National HIV Surveillance System (NHSS)

Sponsor

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).

Description

The National HIV Surveillance System is the Nation's source for timely information on HIV infection. CDC funds and assists state and local health departments to collect the information. Health departments report their data to CDC.

Since the epidemic was first identified in the United States in 1981, population-based AIDS surveillance has been used to track the progression of HIV disease. Since 1985, states have gradually implemented a standardized confidential name-based approach for HIV surveillance. By April 2008, all 50 states, the District of Columbia, and 6 U.S. dependent areas had fully integrated HIV and AIDS surveillance and had laws or regulations requiring confidential reporting by name for adults, adolescents, and children with confirmed HIV infection.

All 50 states, the District of Columbia, and U.S. dependent areas report cases of HIV infection to CDC by using a uniform surveillance case definition and case report form. The original definition has been modified several times. The most recent modification was in 2008 when the surveillance case definition for HIV infection among adults and adolescents was revised to incorporate an HIV infection staging system that categorizes AIDS as HIV infection, stage 3.

Primary Content

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. HIV infection and AIDS data are nationally representative.

Demographic Data

Age, gender, race, ethnicity, and state of residence

Years Collected

Since 1981

Data Collection Schedule

Continuously. The HIV Surveillance Report is published annually. Supplemental reports are published on an ad hoc basis and are available online at http://www.cdc.gov/hiv/default.htm (accessed October 20, 2022). Data are also available at CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus, https://gis.cdc.gov/grasp/nchhstpatlas/tables.html (accessed October 20, 2022).

Geographic Estimates

National, state, region, and metropolitan statistical area

Notes

Data for the NHQDR are downloaded either from CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus, or from the HIV Surveillance Supplemental Reports.

Contact Information

Agency home page: https://www.cdc.gov/. Accessed October 20, 2022.
Data system home page: https://www.cdc.gov/hiv/statistics/surveillance/systems/index.html. Accessed October 20, 2022.

References

HIV Surveillance Report. https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Accessed October 20, 2022.

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)

Description

NHAMCS collects data on the utilization and provision of medical care services in hospital emergency departments (EDs) and outpatient departments (OPDs). Specially trained interviewers visit the sampled facilities before their participation in the survey to explain survey procedures, verify eligibility, and develop a sampling plan. Before 2012, NHAMCS relied on paper instruments; the survey switched to a computerized questionnaire in 2012. Each emergency department is randomly assigned to a 4-week reporting period. During this period, data for a systematic random sample of visits are recorded by Census interviewers using a computerized Patient Record Form.

Survey Sample Design

NHAMCS is designed as a national probability sample of visits to EDs and OPDs of nonfederal, short-stay, and general hospitals in the United States. NHAMCS uses a 4-stage probability design that involves samples of primary sampling units (PSUs), hospitals within PSUs, clinics within hospitals, and patient visits within clinics or emergency service areas. Data are obtained on patient characteristics such as age, sex, race, and ethnicity, and visit characteristics such as patient's reason for visit, provider's diagnosis, services ordered or provided, and treatments, including medication therapy. In addition, data about the facility are collected as part of a survey induction interview.

Primary Survey Content

Information is obtained on various aspects of ED and OPD patient visits, including patient, hospital, and visit characteristics. The survey instrument is redesigned every 2 to 4 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; intentionality of injury, if any; physician's diagnoses; diagnostic services ordered or provided; procedures provided; medications; providers seen; visit disposition; immediacy with which patient should be seen; and expected source of payment. Items collected that are specific to the ED include mode of arrival, waiting time, duration of time in the ED, initial vital signs, and cause of injury.

Population Targeted

The survey is a representative sample of visits to EDs and OPDs of nonfederal, short-stay, or general hospitals, exclusive of federal, military, and Veterans Affairs hospitals, located in the 50 states and the District of Columbia. Telephone contacts and visits for administrative purposes are excluded. NHAMCS is weighted to give national estimates of ED and hospital OPD visits.

Demographic Data

Patients' age, gender, race, and ethnicity

Years Collected

Since 1992

Data Collection Schedule

Annual

Geographic Estimates

National; U.S. Census Bureau regions

Contact Information

Agency home page: https://www.cdc.gov/nchs. Accessed September 13, 2022.
Data system home page: https://www.cdc.gov/nchs/ahcd.htm. Accessed September 13, 2022.

References

2010 NHAMCS Outpatient Department Summary Tables, https://www.cdc.gov/nchs/data/ahcd/nhamcs_outpatient/2010_opd_web_tables.pdf. Accessed September 13, 2022.

2017 National Hospital Ambulatory Medical Care Survey Public Use Data File Documentation. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS/doc17_ed-508.pdf. Accessed September 13, 2022.

National Immunization Survey – Child (NIS-Child)

Sponsor

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Immunization and Respiratory Diseases (NCIRD) and National Center for Health Statistics (NCHS)

Description

NIS is a continuing nationwide telephone sample survey to monitor vaccination coverage rates among children ages 19-35 months.

The first stage of survey administration is conducted using telephone interviews with households having age-eligible children. In the second stage, provider reports of vaccination information from the child's medical record are obtained.

Survey Sample Design

In each of 56 or more state and local geographic areas (which together make up the United States), NIS draws independent quarterly samples of telephone numbers and then uses random-digit dialing to identify households with one or more children ages 19-35 months. Until 2011, NIS surveyed only landline telephones. A cellular telephone sample was added in 2011.

In the telephone interview, the interviewer collects vaccination information for each child who meets the age criterion and obtains permission to contact the providers of the child's vaccinations. In a second phase, a mail survey, the NIS asks the providers to report vaccination information from the child's medical record. This information is generally more accurate and complete than the household information.

Primary Survey Content

Data collected for children ages 19-35 months include vaccination status and timing for diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTP/DT/DTaP); polio vaccine;

measles, mumps, and rubella vaccine (MMR); *Haemophilus influenzae* type B vaccine (Hib); hepatitis B vaccine (Hep B); varicella zoster vaccine; pneumococcal conjugate vaccine (PCV); hepatitis A (Hep A); influenza; and rotavirus vaccine. The data are collected by race and ethnicity, income, location of residence, geographic division, state, and selected urban areas.

Population Targeted

Children ages 19-35 months living in the United States at the time of the interview

Demographic Data

Gender, race/ethnicity, income, location of residence, four U.S. Census Bureau regions

Years Collected

Since 1994. Data collection for varicella began in July 1996; data collection for PCV began in July 2001.

Data Collection Schedule

Quarterly samples, reported annually

Geographic Estimates

National, state, and local areas

Contact Information

Agency home page: https://www.cdc.gov/vaccines/index.html. Accessed October 20, 2022.
NIS estimates home page: https://www.cdc.gov/vaccines/imz-managers/nis/about.html. Accessed October 20, 2022.
Data system and information for survey respondents' home page: https://www.cdc.gov/vaccines/imz-managers/nis/participant/. Accessed October 20, 2022.

References

CDC. National Immunization Survey-Child, A User's Guide for the 2019 Public-Use Data File. https://www.cdc.gov/vaccines/imz-managers/nis/downloads/NIS-PUF19-DUG.pdf. Accessed October 20, 2022.

Zell ER, Ezzati-Rice TM, Battaglia MP, et al. National Immunization Survey: the methodology of a vaccination surveillance system. Public Health Rep 2000; 115(1):65-77.

National Immunization Survey – Teen (NIS-TEEN)

Sponsor

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Immunization and Respiratory Diseases (NCIRD) and National Center for Health Statistics (NCHS)

Description

NIS is a continuing nationwide telephone sample survey to monitor vaccination coverage rates among children ages 19 to 35 months. Starting in 2006, NIS-Teen was established to collect similar information for adolescents ages 13-17 years. NIS-Teen was conducted for a national sample in the 4th quarters of 2006 and 2007 and expanded to an annual sample in each of 56 or more state and local geographic areas starting in 2008.

The first stage of survey administration is conducted using telephone interviews with households having age-eligible children. In the second stage, provider reports of vaccination information from the child's medical record are obtained.

Survey Sample Design

In each of 56 or more state and local geographic areas (which together make up the United States), NIS draws independent quarterly samples of telephone numbers and then uses random-digit dialing to identify households that have one or more children ages 19-35 months or 13-17 years. Until 2011, the NIS surveyed only landline telephones. A cellular telephone sample was added in 2011.

In the telephone interview, the interviewer collects vaccination information for each child who meets the age criterion and obtains permission to contact the providers of the child's vaccinations. In a second phase, a mail survey, NIS asks the providers to report vaccination information from the child's medical record. This information is generally more accurate and complete than the household information.

Primary Survey Content

Data collected for children ages 13-17 years include vaccination status and timing for tetanus, diphtheria, and acellular pertussis vaccine (TDaP), varicella vaccine, meningococcal conjugate vaccine, and human papillomavirus (HPV) vaccine. The data are collected by race and ethnicity, income, location of residence, geographic division, state, and selected urban areas.

Population Targeted

Children ages 13-17 years living in the United States at the time of the interview

Demographic Data

Gender, race/ethnicity, income, location of residence, four U.S. Census Bureau regions

Years Collected

Since 2006

Data Collection Schedule

Quarterly samples, reported annually

Geographic Estimates

National, state, and local areas

Contact Information

Agency home page: https://www.cdc.gov/vaccines/index.html. Accessed October 20, 2022.
NIS estimates home page: https://www.cdc.gov/vaccines/imz-managers/nis/about.html. Accessed October 20, 2022.
Data system and information for survey respondents' home page: https://www.cdc.gov/vaccines/imz-managers/nis/participant/. Accessed October 20, 2022.

Notes

The 2020 data reflect adolescent vaccination coverage before the 2019 Novel Coronavirus (COVID-19) pandemic which disrupted routine immunization services.

References

Zell ER, Ezzati-Rice TM, Battaglia MP, et al. National Immunization Survey: the methodology of a vaccination surveillance system. Public Health Rep 2000; 115(1):65–77.

NIS-TEEN survey documentation: https://www.cdc.gov/vaccines/imz-managers/nis/datasets-teen.html. Accessed October 20, 2022.

National Program of Cancer Registries (NPCR)

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

Description

NPCR provides funds and guidance to states and U.S. territories to implement and enhance their cancer registries. As of 2017, NPCR supports central registries and promotes the use of registry data in 46 states, the District of Columbia, Puerto Rico, the Pacific Island jurisdictions, and the U.S. Virgin Islands.

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

Population Targeted

NPCR registries collect data about cancer cases occurring in approximately 97% of the U.S. population.

Demographic Data

Sex, age, race/ethnicity

Years Collected

Since 1995

Data Collection Schedule

Data collection is ongoing. Reports are published periodically. Since 2001, central cancer registries have been reporting data annually.

Geographic Estimates

National, participating states and DC

Contact Information

Agency homepage: https://www.cdc.gov. Accessed September 7, 2022.
Data system homepage: https://www.cdc.gov/cancer/npcr. Accessed September 7, 2022.

References

U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2019 submission data: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://gis.cdc.gov/Cancer/USCS/#/AtAGlance/ (accessed September 7, 2022), June 2020. Additional information available at: https://www.cdc.gov/uscs (accessed September 7, 2022).

National Tuberculosis Surveillance System (NTSS)

Sponsor

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Division of Tuberculosis Elimination (DTBE).

Description

Reports of verified cases of tuberculosis (RVCT) are submitted to DTBE, CDC, by 60 reporting areas (the 50 states, the District of Columbia, New York City, Puerto Rico, and seven other jurisdictions in the Pacific and Caribbean). In January 1993, an expanded system was developed to collect additional information for each reported TB case to better monitor trends in TB and TB control. A software package (SURVS-TB) for data entry, analysis, and transmission of case reports to CDC was designed and implemented as part of the expanded TB surveillance system. In 1998, the Tuberculosis Information Management System (TIMS) replaced SURVS-TB. Beginning in 2009, case reports no longer had a specific software requirement.

Two CDC-sponsored software options - the NEDSS base system (NBS) and the electronic Report of Verified Case of Tuberculosis (eRVCT) were introduced as two options for reporting TB cases to CDC. In addition, commercial- and state-developed software came into use. TIMS was allowed to be used for reporting 2009 results in instances where other software was not yet available.

TIMS was officially retired for case completion in December 2010 for cases occurring in 2008 and prior. In 2016, the platform for the eRVCT was replaced by the National Tuberculosis Surveillance System for Case Reporting (NTSS-CR), a web-based RVCT form to allow data entry for case management and reporting to CDC. All systems reporting TB since TIMS report cases using HL7 messages following the TB Case Notification specification.

In total, 7,860 TB cases were reported in the United States in 2021.

Primary Content

Number of new TB cases, patient management, and program evaluation.

In the expanded system started in January 1993, the RVCT form for reporting TB cases was revised to collect information on occupation, initial drug regimen, HIV test results, history of substance abuse and homelessness, and residence in correctional or long-term care facilities at the time of diagnosis.

RVCT Follow up Report-1 was added to collect drug susceptibility results for the initial M. tuberculosis isolate from patients with culture-positive disease. To evaluate the outcomes of TB therapy, RVCT Follow up Report-2 was added. This report collects information on the reason and date therapy was stopped, type of healthcare provider, sputum culture conversion, use of directly observed therapy, and results of drug susceptibility testing for the final M. tuberculosis isolate from patients with culture-positive disease.

In 2009, the RVCT form was further expanded to collect variables to reflect the changing field of TB epidemiology and to collect more accurate data on TB cases. New variables include:

- Count status to address TB burden,
- Pediatric TB to collect information on guardians and travel outside the United States,
- Nucleic acid amplification test,
- Initial chest CT scan or other chest imaging study,
- Interferon gamma release assay blood test,
- Primary reason evaluated for TB disease,
- Additional TB risk factors,
- Immigrant status,
- Genotyping accession number,
- Whether a patient moved during treatment and where, and
- Reason therapy was extended for more than 12 months.

Other variables were modified to include the addition of dates that specimens for diagnostic tests were collected and reported.

Population Targeted

Civilian population residing in the United States with a diagnosis of TB

Demographic Data

Age, gender, race, and country of origin

Years Collected

In aggregate form, since 1953; in individual case forms since 1985

Data Collection Schedule

Annual

Geographic Estimates

National and state

Contact Information

Agency home page: https://www.cdc.gov. Accessed September 7, 2022.
Data system home page: https://www.cdc.gov/tb. Accessed September 7, 2022.

References

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of Tuberculosis Elimination. Reported tuberculosis in the United States, 2020. Atlanta, GA: Centers for Disease Control and Prevention; October 2020. https://www.cdc.gov/tb/statistics/reports/2020/default.htm (accessed September 7, 2022).

National Vital Statistics System: Linked Birth and Infant Death Data (NVSS-L)

Sponsor

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS).

Description

NCHS's Division of Vital Statistics obtains information on births and deaths from the registration offices of each of the 50 states, New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

Before 1972, NCHS processed microfilm copies of all death certificates and a 50% sample of birth certificates received from all registration areas. In 1972, some states began sending their data to NCHS through the Cooperative Health Statistics System (CHSS). States that participated in the CHSS program processed 100% of their death and birth records and sent the entire data file to NCHS on computer tapes.

Currently, data are sent to NCHS through the Vital Statistics Cooperative Program (VSCP), following the same procedures as CHSS. Starting in 1985, all 50 states and the District of Columbia have participated in VSCP.

In the linked birth and infant death dataset, the information from the death certificate is linked to the information from the birth certificate for each infant less than age 1 who dies in the United States, Puerto Rico, Virgin Islands, and Guam. Starting with data year 1995, linked file data are produced in a period data format preceding the release of the corresponding birth cohort format. The 2005 linked file contains a numerator file that consists of all infant deaths occurring in 2005 that have been linked to their corresponding birth certificates, whether the birth occurred in 2004 or 2005.

Other changes to the dataset, starting with 1995 data, include addition of record weights to correct for the 1.0% to 1.4% of records that could not be linked in 2000 to 2005 (2% in 1995 to 1999) and imputation for unstated birth weight.

Primary Content

The vital statistics general mortality data are a fundamental source of geographic and cause-of-death information and some demographic information. The birth certificate is the primary source of demographic information, such as age, race, and Hispanic origin of the parents; maternal education; live birth order; and mother's marital status; and of maternal and infant health information, such as birth weight, period of gestation, plurality, prenatal care use, and maternal smoking.

Population Targeted

Infants in 50 states and the District of Columbia

Demographic Data

Age, gender, race, and Hispanic origin of infant and parents, mother's education and marital status

Years Collected

Linked data are available for the data years 1983-1991 and 1995-2019

Data Collection Schedule

Annual

Geographic Estimates

National, state

Place of death is classified by state and county. In residence classification, all deaths are allocated to the usual place of residence as reported on the death certificate and are classified by state, county, and city.

Notes

NHQDR tables from NVSS-L, NVSS-M, and NVSS-N report urbanization levels. Counties were classified according to their metropolitan status using the National Center for Health Statistics (NCHS) Urban–Rural Classification Scheme.

- Metropolitan counties:
  - Large Central - Central counties in metro areas of 1 million or more population
  - Large Fringe - Outlying counties in metro areas of 1 million or more population
  - Medium - Counties in metro areas of 250,000-999,999 population
  - Small - Counties in metro areas of 50,000-249,999 population
- Nonmetropolitan counties:
  - Micropolitan - Counties in areas with an urban cluster of 10,000-49,999 population
  - Noncore – Nonmicropolitan

The 2000-2015 NVSS estimates for the 2003-2017 NHQDR used the 2006 NCHS Metropolitan statistical areas file, which was based on the 2000 OMB standards and on the 2000 census.

Since the 2018 NHQDR, NVSS estimates have used the 2013 NCHS metropolitan statistical areas file, which was based on the 2013 OMB standards and on Vintage 2012 postcensal estimates of the resident U.S. population.

Data on mother's educational attainment, tobacco use during pregnancy, and prenatal care based on the 2003 revision are not comparable with data based on the 1989 revision of the U.S. Standard Certificate of Live Birth.

Contact Information

Agency home page: https://www.cdc.gov. Accessed September 13, 2022.
Data system home page: https://www.cdc.gov/nchs/nvss/linked-birth.htm. Accessed September 13, 2022.

References

Ely DM, Driscoll MacDorman AK. Infant mortality statistics from the 2019 period linked birth/infant death data file. National Vital Statistics Reports; vol 70 no 14. Hyattsville, MD: National Center for Health Statistics. 2021.

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)

Description

National Vital Statistics System – Mortality (NVSS-M) 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 2.4 to 2.5 million annually).

By law, registration of deaths is a funeral director's responsibility. Administrative records (death certificates) completed by funeral directors, physicians, medical examiners, and coroners are filed with state vital statistics offices. Selected statistical information is forwarded to NCHS to be merged into a national statistical file.

States are phasing in the 2003 revision of the standard certificates. Those that have not revised yet are using the 1989 version of the standard certificates. 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 a physician, medical examiner, or coroner.

Currently, data are sent to NCHS through the Vital Statistics Cooperative Program (VSCP). All 50 states and the District of Columbia have participated in VSCP since 1985.

Primary Content

Demographic and medical information and information about death event such as age at death, Hispanic origin, race, sex, marital status, decedent's residence, place of birth, educational attainment, underlying and multiple causes of death, injury at work, place death occurred, day of week of death, month of death, and year of death

Population Targeted

U.S. population

Demographic Data

Sex, race, Hispanic origin, age at death, place of decedent's residence, educational attainment, and marital status

Years Collected

The mortality reporting data system began in 1880, but not all states participated before 1933. Coverage for deaths has been complete since 1933.

Data Collection Schedule

Annual

Geographic Estimates

National, regional, state, and county but access below national has limitations

Notes

Beginning with 1989 data, some changes were initiated to increase confidentiality. Identifying information, including date of death and geographic identifiers for counties of fewer than 100,000 people, was not available for public use. Beginning with 2005 data, geographic identifiers below the national level were removed from the public use data files. Data are still accessible using tools such as WONDER (https://wonder.cdc.gov, accessed October 20, 2022). Data for NHQDR measures related to drug overdose deaths involving opioid are downloaded from WONDER.

The item on educational attainment was changed on the 2003 revision of the standard certificate. Some states have implemented the 2003 revision, while others still use the 1989 revision of the U.S. Standard Certificate of Death. One state does not have either version of the item.

NHQDR tables from NVSS report urbanization levels. Counties were classified according to their metropolitan status using the National Center for Health Statistics (NCHS) Urban–Rural Classification Scheme.

- Metropolitan counties:
  - Large Central - Central counties in metro areas of 1 million or more population
  - Large Fringe - Outlying counties in metro areas of 1 million or more population
  - Medium - Counties in metro areas of 250,000-999,999 population
  - Small - Counties in metro areas of 50,000-249,999 population

- Nonmetropolitan counties:
  - Micropolitan - Counties in areas with an urban cluster of 10,000-49,999 population
  - Noncore – Nonmicropolitan

The 2000-2015 NVSS estimates for the 2003-2017 NHQDR used the 2006 NCHS metropolitan statistical areas file, which was based on the 2000 OMB standards and on the 2000 census.

Since the 2018 NHQDR, NVSS estimates have used the 2013 NCHS metropolitan statistical areas file, which was based on the 2013 OMB standards and on Vintage 2012 postcensal estimates of the resident U.S. population.

Race and ethnic origin are separate items on the death certificate. As of 1997, all states report Hispanic origin. The categories reported include Mexican, Puerto Rican, Cuban, Central and South American, and Other Hispanic.

Beginning in 1992, California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington reported expanded Asian and Pacific Islander categories: 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. Beginning with data for 2003, multiple-race data are available for selected states. In addition, the previous distinction about particular Asian groups is being replaced by the categories available on the 2003 revision of the standard certificate.

Contact Information

Agency home page: https://www.cdc.gov/nchs. Accessed October 20, 2022.
Data system home page: https://www.cdc.gov/nchs/deaths.htm. Accessed October 20, 2022.

References

National Vital Statistics Reports. https://www.cdc.gov/nchs/products/nvsr.htm. Accessed October 20, 2022.

Murphy SL, Xu J, Kochanek KD. Deaths: Final Data for 2010. National Vital Statistics Reports; Vol. 61, No 4. Hyattsville, MD: National Center for Health Statistics; 2013.

Hoyert DL, Xu JQ. Deaths: Preliminary Data for 2011. National Vital Statistics Reports; Vol 61, No 6. Hyattsville, MD: National Center for Health Statistics; 2012.

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).

Description

National Vital Statistics System - Natality (NVSS-N) files include approximately 4 million birth records annually, with 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.

State laws require birth certificates to be completed for all births. The registration of births is the responsibility of the professional attendant at birth, generally a physician or midwife. Federal law mandates national collection and publication of birth and other vital statistics data.

Birth certificates completed by physicians and midwives are filed with state vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Standard forms for the data collection and model procedures for the uniform registration of events are developed and recommended for state use through cooperative activities of the states and NCHS (Vital Statistics Cooperative Program).

Primary Content

Demographic information about the birth, such as year, date, place of birth, age, race and Hispanic origin of mother, and live-birth order.

Maternal and infant health information about the birth, such as maternal age, live-birth order, race and Hispanic origin, marital status, attendant at birth, method of delivery, period of gestation, birth weight, plurality, medical risk factors, maternal weight gain, obstetric procedures, characteristics of labor and delivery, and congenital anomalies.

Population Targeted

U.S. resident population

Demographic Data

Child: Sex

Mother and father: Race, Hispanic origin (beginning in 1978), age, place of mother's residence, and educational attainment (beginning in 1978) (education of father is currently collected on the 2003 revision of the standard certificate)

Mother: marital status

Race and Hispanic origin are separate items on the birth certificate. As of 1993, all states have reported expanded Asian and Pacific Islander categories of Asian Indian, Korean, Vietnamese, Samoan, and Guamanian. The rest of the states report 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.

Beginning with data for 2003, multiple-race data are available for selected states and the previous distinction about particular Asian groups is being replaced by the categories available on the 2003 revision of the standard certificate.

Years Collected

The national birth registration system was established in 1915. Not all states participated before 1933. Coverage for births has been complete since 1933.

Data Collection Schedule

Annual

Geographic Estimates

National, regional, state, county, and city, but access below national has limitations

Notes

Beginning with 1989 data, some changes were initiated to increase confidentiality. Identifying information, including geographic identifiers for counties of fewer than 100,000 people, is not available for public use. Beginning with 2005 data, geographic identifiers below the national level were removed from the public use data files. Data are still accessible using tools such as VitalStats (https://www.cdc.gov/nchs/data_access/vitalstatsonline.htm; accessed September 13, 2022) and WONDER (https://wonder.cdc.gov, accessed September 13, 2022). In addition, restricted data files with geographic identifiers are available and may be requested (https://www.cdc.gov/nchs/nvss/dvs_data_release.htm, accessed September 13, 2022).

Data on mother's educational attainment, tobacco use during pregnancy, and prenatal care based on the 2003 revision are not comparable with data based on the 1989 revision of the U.S. Standard Certificate of Live Birth.

NHQDR tables from NVSS-L, NVSS-M, and NVSS-N report urbanization levels. Counties were classified according to their metropolitan status using the National Center for Health Statistics (NCHS) Urban–Rural Classification Scheme.

- Metropolitan counties:
  - Large Central - Central counties in metro areas of 1 million or more population
  - Large Fringe - Outlying counties in metro areas of 1 million or more population
  - Medium - Counties in metro areas of 250,000-999,999 population
  - Small - Counties in metro areas of 50,000-249,999 population
- Nonmetropolitan counties:
  - Micropolitan - Counties in areas with an urban cluster of 10,000-49,999 population
  - Noncore – Nonmicropolitan.

The 2000-2015 NVSS estimates for the 2003-2017 NHQDR used the 2006 NCHS metropolitan statistical areas file, which was based on the 2000 OMB standards and on the 2000 census.

Since the 2018 NHQDR, NVSS estimates have used the 2013 NCHS metropolitan statistical areas file, which was based on the 2013 OMB standards and on Vintage 2012 postcensal estimates of the resident U.S. population.

Contact Information

Agency home page: https://www.cdc.gov/nchs. Accessed September 23, 2022.
Data system home page: https://www.cdc.gov/nchs/births.htm. Accessed September 23, 2022.

References

Martin JA, Hamilton BE, Ventura SJ, et al. Births: Final Data for 2010. National Vital Statistics Reports; Vol. 61, No. 1. Hyattsville, MD: National Center for Health Statistics; 2012.

Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2011. National Vital Statistics Reports; Vol. 61, No. 5. Hyattsville, MD: National Center for Health Statistics; 2012.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey

Sponsor

Centers for Medicare & Medicaid Services (CMS).

Description

HHCAHPS is designed to measure the experiences of people receiving home health care from Medicare-certified home health agencies (HHAs). The survey is conducted by multiple survey vendors working under contract with HHAs and involves ongoing data collection with monthly and quarterly data submissions. Survey vendors prepare and submit data files to the HHCAHPS Survey Data Center.

Official HHCAHPS scores have been publicly reported on the Medicare Compare website (https://www.medicare.gov/care-compare/ accessed October 20, 2022) since April 2012. HHCAHPS scores are reported four times each year, with the oldest quarter of surveys rolling off as the newest quarter rolls on.

Survey Sample Design

Agencies have a choice of requesting the survey vendor to conduct the HHCAHPS in one of three survey modes: mail only, telephone only, and mixed (mail with telephone followup), each of which requires multiple attempts to contact patients. HHAs survey patients every month of the year.

HHCAHPS is available in official English, Spanish, Simplified and Traditional Chinese, Russian, and Vietnamese language translations.

Primary Survey Content

The HHCAHPS Survey instrument contains 34 items that cover topics such as access to care and patient care, communications between providers and patients, and specific care issues.

The core of the survey contains 25 items that ask “how often” or whether patients experienced significant aspects that are expected in their home health care. Another nine “About You” items ask about the patient’s attributes. The survey also has two global rating items: (1) overall rating of care received, and the (2) patient’s willingness to recommend the HHA to family and friends.

Population Targeted

HHCAHPS is administered to patients age 18 and over who have received at least two home health visits in the past 2 months. The survey is administered to Medicare-certified agency patients but HHCAHPS is not restricted to Medicare patients.

Demographic Data

Age, gender, overall health and mental health status, education, race/ethnicity, language spoken at home, and living arrangement

Years Collected

Since October 2010 (for publicly reported data)

Data Collection Schedule

Collected monthly and reported quarterly

Geographic Estimates

National and State

Notes

In response to the COVID-19 public health emergency, CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for 2020 quarters 1 and 2. Provider participation in Q1 and Q2 2020 was voluntary and results were not publicly reported. Therefore, the NHQDR tables using 2020 Home Health CAHPS data are based on Q3 and Q4 2020 data only. This approach is consistent with the publicly available data files on https://www.cms.gov in the Provider Data Catalog for 2020 for the Home Health CAHPS.

Contact Information

Agency home page: https://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://homehealthcahps.org. Accessed October 20, 2022.

References

The survey and its protocols for sampling, data collection, coding, and submission are in the HHCAHPS Protocols and Guidelines Manual, Version 14.0, January 2022 (https://homehealthcahps.org/Portals/0/SurveyMaterials/PandGManual.pdf; accessed October 20, 2022).

Home Health Outcome and Assessment Information Set (OASIS)

Sponsor

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). Home Health Quality Initiative

Description

OASIS is the instrument/data collection tool home health agencies use to collect and report performance data. Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid except patients receiving pre- or postnatal services only.

Home health agencies encode and transmit data using software available from CMS or software that conforms to CMS standard electronic record layout, editing specifications, and data dictionary and that includes the required OASIS dataset.

Beginning in January 2010, home health agencies have been required to collect a revised version of the OASIS dataset (OASIS-C). OASIS-C includes data items supporting measurement of rates

for use of specific evidence-based care processes. From a national policy perspective, CMS anticipates that these process measures will promote the use of best practices across the home health industry.

The OASIS-based quality performance data are posted on the "Health Compare" website (https://www.medicare.gov/care-compare/; accessed October 20, 2022) since 2003. These measures include outcome measures which indicate how well home health agencies assist their patients in regaining or maintaining their ability to function and process measures which evaluate the rate of home health agency use of specific evidence-based processes of care.

Primary Content

Completed by home health agency (HHA) personnel, the OASIS contains data elements that represent core items obtained from a comprehensive assessment of adult home care patients. These data are used to measure patient outcomes for purposes of outcome-based quality improvement.

Data collected in OASIS include demographic and patient history, living arrangements, supportive assistance, sensory status, integumentary (skin) status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, and information collected at inpatient facility admission or agency discharge.

Population Targeted

U.S. adult, home care patients who are responsive

Demographic Data

Gender, age, race/ethnicity, state of residence, marital status, expected source of payment, and living arrangement

Years Collected

Since 1999

Data Collection Schedule

Most OASIS data items are designed to be collected at the start of care and every 2 months thereafter until and including time of discharge.

Geographic Estimates

National and state

Notes

Since 2018, NHQDR has used the 100% OASIS annual assessment files residing on CMS's Chronic Conditions Data Warehouse. The sample included the latest episode per patient in the calendar year. Numerators and denominators are defined based on the OASIS User's Manual available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual (accessed October 20, 2022).

Since 1999, numerous changes have occurred within the healthcare system, including specific recommendations for changes in the area of home healthcare quality measurement. The OASIS User Manuals documented the changes.

OASIS-C2 was developed from OASIS-C1/ICD-10 to accommodate new data being collected for the Home Health Quality Reporting Program in support of the IMPACT Act. The OASIS-C2 data item set was approved by the Office of Management and Budget (OMB) on December 9, 2016, and were implemented on January 1, 2017.

OASIS-D1 is the 2020 version of the OASIS dataset. The OASIS-D1 All Items instrument and the OASIS-D1 Follow-Up instrument were revised to accommodate the changes effective January 1, 2020. The original OASIS-D versions for all other time points remain in effect as of January 1, 2020. OASIS-D was approved by OMB on December 6, 2018, with an expiration date of December 31, 2021. The valid OMB control number for this information collection is 0938-1279.

In response to the 2019 Novel Coronavirus (COVID-19) pandemic, the CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for Quarter 1 and Quarter 2020. Since provider participation in Q1 and Q2 2020 was voluntary, the record number of the 2020 OASIS database are smaller than previous years. This change affected the NHQDR tables. However, because the sample sizes for the NHQDR measures were relatively large (mostly a few millions), the percentage estimates for each quality measures were similar to those in the previous years.

Contact Information

Agency home page: https://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits. Accessed October 20, 2022.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) Survey

Sponsor

Centers for Medicare & Medicaid Services (CMS).

Description

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally. Official HCAHPS scores, based on four consecutive quarters of patient surveys, have been publicly reported through the Medicare Compare website, https://www.medicare.gov/care-compare/ (accessed September 13, 2022) since 2008. HCAHPS scores are reported four times each year, with the oldest quarter of surveys rolling off as the newest quarter is added. A link to the downloadable version of HCAHPS results is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS (accessed September 13, 2022). In April

2020, 4,509 hospitals publicly reported HCAHPS scores based on more than 3 million completed surveys. On average, almost 8,000 patients complete the HCAHPS Survey everyday.

Survey Sample Design

HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical and maternity care service lines are eligible for the survey; HCAHPS is not restricted to Medicare patients. Hospitals may use an approved survey vendor or collect their own HCAHPS data, if approved by CMS to do so. HCAHPS can be implemented in four survey modes: mail, telephone, mixed (mail with telephone followup), or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients.

Hospitals must survey patients throughout each month of the year. HCAHPS is available in official English, Spanish, Chinese, Russian, Vietnamese, and Portuguese translations. The survey and its protocols for sampling, data collection, coding and submission can be found in the HCAHPS Quality Assurance Guidelines manual under the Quality Assurance section of the official HCAHPS website at https://hcahpsonline.org/en/quality-assurance (accessed September 13, 2022).

Primary Survey Content

The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The core of the survey contains 21 items that ask “how often” or whether patients experienced a critical aspect of hospital care, rather than whether they were “satisfied” with their care. The survey also includes four screener items that direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support congressionally mandated reports. Hospitals may add supplemental items after the core HCAHPS items.

Population Targeted

Eligible patients at all acute-care hospitals in the United States

Demographic Data

Gender, age, educational attainment, race/ethnicity, language spoken at home, overall health status, and mental or emotional health status

Years Collected

Since 2006

Data Collection Schedule

Continuous

Geographic Estimates

National and state

Notes

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.

In response to the 2019 COVID-19 public health emergency, CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for 2020 quarters 1 and 2. Provider participation in Q1 and Q2 2020 was voluntary, and results were not publicly reported. Therefore, the NHQDR tables using 2020 Hospital CAHPS data are based on Q3 and Q4 2020 data only. This approach is consistent with the publicly available data files on https://www.cms.gov in the Provider Data Catalog for 2020 for the Hospital CAHPS.

Contact Information

Agency home page: https://www.medicare.gov. Accessed September 13, 2022.
Data system home page: https://www.hcahpsonline.org. Accessed September 13, 2022.

References

Giordano LA, Elliott MN, Goldstein E, Lehrman WG, Spencer PA. Development, implementation, and public reporting of the HCAHPS Survey. Med Care Res Rev. 2010;67(1):27-37.

Elliott MN, Cohea CW, Lehrman WG, Goldstein EH, Cleary PD, Giordano LA, Beckett MK, Zaslavsky AM. Accelerating improvement and narrowing gaps: trends in patients' experiences with hospital care reflected in HCAHPS public reporting. Health Serv Res. 2015;50:1850-67. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693845/. Accessed September 13, 2022.

Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Sponsor

Centers for Medicare & Medicaid Services (CMS), CAHPS Hospice Survey

Description

CMS has implemented the CAHPS Hospice Survey to measure the experiences that patients and their caregivers had with hospice care. The survey was developed to:

- Provide a source of information from which selected measures could be publicly reported to beneficiaries and their family members as a decision aid for selection of a hospice program.
- Aid hospices with their internal quality improvement efforts and external benchmarking with other facilities.
- Provide CMS with information for monitoring the care provided.

The CAHPS Hospice Survey is administered using three modes: mail only, telephone only, and mixed mode (mail with telephone followup). CAHPS Hospice Survey administration begins 2 months after the month of patient death. The data collection process must be completed within

42 calendar days after initial contact. Submission of data to the CAHPS Hospice Survey Data Warehouse occurs quarterly.

The CAHPS Hospice Survey mail materials are available in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish, and Korean. The Chinese mail survey is provided in both traditional and simplified characters and targets both Mandarin and Cantonese speakers. The CAHPS Hospice Survey telephone script is available in English, Spanish, and Russian.

Survey Sample Design

In general, all Medicare-certified hospices must participate in the CAHPS Hospice survey to receive annual payment updates. Hospices with 50 to 699 survey-eligible decedents/caregivers in the prior year are required to survey all cases (conduct a census) and attempt to obtain as many completes as possible.

Hospices with 700 or more survey-eligible decedents/caregivers in the prior year are required to survey a minimum sample of 700 using an equal-probability design. Hospices with fewer than 50 survey-eligible decedents/caregivers during the prior calendar year are exempt from the survey data collection and reporting requirements. Decedents must be age 18 and over at the time of death.

While there is no requirement for census administration, hospices with 700 or more survey-eligible decedents/caregivers may conduct a census, if desired. Survey-eligible decedents/caregivers are defined as the group of decedent and caregiver pairs who meet all the criteria for inclusion in the survey sample.

Primary Survey Content

The CAHPS Hospice Survey consists of 47 questions and is administered to the primary informal caregiver of the decedent who died while receiving hospice care.

Topics include:

- Communication with family.
- Getting timely help.
- Treating patients with respect.
- Emotional and spiritual support.
- Help for pain and symptoms.
- Training family to care for patient.
- Rating of this hospice.
- Willingness to recommend this hospice.

Population Targeted

Decedents age 18 and over in a hospice facility in the United States

Demographic Data

Age, gender, race/ethnicity, language spoken at home, and education

Years Collected

Since 2015

Data Collection Schedule

Monthly since 2015

Geographic Estimates

National and state

In response to the 2019 COVID-19 public health emergency, CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for 2020 quarters 1 and 2. Provider participation in Q1 and Q2 2020 was voluntary and results were not publicly reported. Therefore, the NHQDR tables using 2020 CAHPS Hospice data are based on Q3 and Q4 2020 data only. This approach is consistent with the publicly available data files on https://www.cms.gov in the Provider Data Catalog for 2020 for the CAHPS Hospice.

Contact Information

Agency home page: http://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://www.hospicecahpssurvey.org. Accessed October 20, 2022.

Hospital Quality Initiative, Hospital Inpatient Quality Reporting Program (Hospital IQR)

Sponsor

Centers for Medicare & Medicaid Services (CMS)

Description

The Hospital IQR Program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.

Under the Hospital IQR program, CMS collects quality data from hospitals paid under the Inpatient Prospective Payment System. The goal is to drive quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their healthcare. It is also intended to encourage hospitals and clinicians to improve the quality and cost of inpatient care provided to all patients.

The data collected through the program are available to consumers and providers on the Hospital Compare website at https://www.medicare.gov/care-compare/ (accessed October 20, 2022). Data for selected measures are also used to pay a portion of hospitals based on the quality and efficiency of care, including the Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, and Hospital Readmissions Reduction Program.

Patients or cases are selected randomly by each hospital according to the sampling requirements outlined in the Hospital IQR manual, https://www.qualitynet.org/inpatient/specifications-manuals (accessed October 20, 2022).

Hospitals submit data to the CMS Clinical Data Warehouse, CMS's central repository for clinical data, according to the Hospital IQR manuals.

Primary Content

A set of hospital care measures approved by the National Quality Forum. These measures will permit consumers, providers, purchasers, and quality improvement professionals to evaluate and compare the quality of care in general acute care hospitals across the nation.

Population Targeted

Hospital inpatients (Medicare and non-Medicare), required for the relevant measure in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands

Demographic Data

Patients' age, gender, race/ethnicity

Years Collected

Since 2015

Data Collection Schedule

Quarterly

Geographic Estimates

National and state

Notes

In response to the COVID-19 public health emergency, CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for 2020 quarters 1 and 2. Provider participation in Q1 and Q2 2020 was voluntary, and results were not publicly reported. Therefore, the NHQDR tables using 2020 CMS IQR data are based on Q3 and Q4 2020 data only.

Contact Information

Agency home page: https://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://www.qualitynet.org. Accessed October 20, 2022.

References

The Hospital IQR manual available at https://www.qualitynet.org/inpatient/specifications-manuals. Accessed October 20, 2022.

Hospital Quality Initiative, Hospital Outpatient Quality Reporting (Hospital OQR) Program

Sponsor

Centers for Medicare & Medicaid Services (CMS)

Description

The Hospital OQR is a pay for quality data reporting program CMS implemented for outpatient hospital services. The Hospital OQR Program was mandated by the Tax Relief and Health Care Act of 2006. This act requires subsection (d) hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome, and efficiency.

Under the Hospital OQR Program, hospitals must meet administrative, data collection and submission, validation, and publication requirements, or receive a 2 percentage point reduction in payment for failing to meet these requirements. The reduction is determined by applying a reporting factor of 0.980 to the Outpatient Prospective Payment System (OPPS) payments and copayments for all applicable services.

In addition to providing hospitals with a financial incentive to report their quality of care measure data, the Hospital OQR Program provides CMS with data to help Medicare beneficiaries make more informed decisions about their healthcare. Hospital quality of care information gathered through the Hospital OQR Program is available on the Hospital Compare website (https://www.medicare.gov/care-compare/; accessed September 7, 2022).

Primary Content

Outpatient care can refer to numerous types of health services, such as emergency department services, observation services, outpatient surgical services, lab tests, and x rays, provided to those who visit a hospital or other healthcare facility.

Hospital Compare provides results on emergency department and outpatient quality measures, which evaluate the quality of care provided to patients. A quality measure converts medical information from patient records into a rate or time that allows facilities to assess their performance. It also helps consumers compare how well patients are being cared for at their local hospitals.

The outpatient measures evaluate the regularity with which a healthcare provider administers the outpatient treatment known to provide the best results for most patients with a particular condition.

The Hospital OQR measures include data collected with various methods to measure patient care outcomes, process of care, imaging efficiency patterns, care transitions, ED-throughput efficiency, health information technology use, care coordination, and patient safety. Data may be collected through chart abstraction, claim volume, or reporting on a hospital process. CMS identified specialty areas that had common and frequent procedures in the hospital outpatient setting. These procedures were identified as colonoscopies and outpatient imaging procedures. Other areas of future focus are outpatient surgery and chemotherapy.

Population Targeted

Hospital outpatients (Medicare and non-Medicare beneficiaries), required for the relevant measure in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Demographic Data

Age, gender, and race/ethnicity.

Years Collected

Since 2006

Data Collection Schedule

Quarterly

Geographic Estimates

National and state.

In response to the COVID-19 public health emergency, CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for 2020 quarters 1 and 2. Provider participation in Q1 and Q2 2020 was voluntary, and results were not publicly reported. Therefore, the NHQDR tables using 2020 CMS OQR data are based on Q3 and Q4 2020 data only.

Contact Information

Agency home page: http://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://www.qualitynet.org. Accessed October 20, 2022.

References

Hospital outpatient specification manual available at https://www.qualitynet.org/outpatient. Accessed October 20, 2022.

Nursing Home Assessment files, Minimum Data Set (MDS)

Sponsor

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS)

Description

The MDS is a key component of Medicare's partnership with the nursing home industry to foster and monitor improved nursing home care outcomes.

Completed by nursing home personnel, the MDS data are collected, encoded, and transmitted for all nursing home residents receiving skilled nursing or long-term services at a Medicare- or Medicaid-certified nursing home. Nursing homes encode and transmit data using software

available from CMS or software that conforms to CMS standard electronic record layout, editing specifications, and data dictionary and that includes the required MDS dataset.

Primary Content

The MDS contains data elements that represent core items obtained from a comprehensive assessment of adult nursing home residents. These data are used to measure patient outcomes for the purpose of outcome-based quality improvement. The information collected includes the residents' health, physical functioning, mental status, and general well-being.

Population Targeted

U.S. nursing home residents

Demographic Data

Gender, age, race/ethnicity, state of residence, marital status, and living arrangement

Years Collected

Since 1998

Data Collection Schedule

MDS data items are designed to be collected at admission to the nursing home and at regular intervals until transfer, discharge, or death

Geographic Estimates

National and state

Notes

Since 2018, the NHQDR has used the Nursing Home Assessment files, MDS 3.0, residing on the Chronic Conditions Data Warehouse as input. The sample included the latest episode in the calendar year with followup assessments, including ongoing stays and excluding deceased residents. Numerators and denominators are defined based on the MDS 3.0 Quality Measures User's Manual available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf (accessed October 20, 2022). Estimates are not risk adjusted.

Contact Information

Agency home page: https://www.cms.gov/. Accessed October 20, 2022.
Data system home page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html. Accessed October 20, 2022.

References

MDS 3.0 Quality Measures User's Manual. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf. Accessed October 20, 2022.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Ryan White HIV/AIDS Program, Information Technology Supplement

Sponsor

U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB)

Description

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medication, and essential support services for low-income people with HIV. The program funds grants to cities, counties, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year, serving more than 50% of people diagnosed with HIV in the United States.

RWHAP-funded grant recipients and providers annually submit client-level data through the Ryan White HIV/AIDS Services Report (RSR). Since 2010, client-level RSR data have been used to assess the numbers and types of clients receiving services and their HIV-related outcomes.

The RSR dataset is HAB's primary source of annual, client-level data collected from more than 2,000 funded grant recipients and subrecipients. The RSR includes clients receiving services from RWHAP funded recipients and providers during the calendar year, regardless of the RWHAP funding stream. RSR data do not include information about the AIDS Drug Assistance Program (ADAP); all ADAP-related information is collected through another data system.

Primary Content

The RSR includes demographic composition of clients served; socioeconomic factors, such as income relative to the poverty threshold, healthcare coverage, and housing status; and clinical information.

Population Targeted

All RWHAP Part A-D recipients and providers submit the annual RSR

Demographic Data

Client-level demographic data include age, race/ethnicity, gender, HIV transmission risk category, income relative to the federal poverty level, healthcare coverage, and housing status

Years Collected

Since 2010

Data Collection Schedule

Annual

Geographic Estimates

National, HHS region, and state

Contact Information

Agency home page: https://www.hrsa.gov/. Accessed October 20, 2022.
Data system home page: https://ryanwhite.hrsa.gov. Accessed September 7, 2022.

References

https://ryanwhite.hrsa.gov/data/reports. Accessed September 7, 2022.

Uniform Data System (UDS)

Sponsor

Health Resources and Service Administration (HRSA), Bureau of Primacy Health Care (BPHC)

Description

UDS is an integrated reporting system used by all grantees of BPHC's Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care programs. Clinical, operational, and financial data collected are used to monitor and evaluate BPHC programs and to analyze annual trends.

UDS tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are reported from grantees at the grantee, state, and national levels. The data are aggregated at the organizational or grantee level and are not granular data at the patient level.

Population Targeted

Patients using HRSA-supported health centers in the United States

Demographic Data

Age, gender, race, ethnicity and language, income

Years Collected

Since 1996

Data Collection Schedule

Data are reported annually in the first quarter of the year

Geographic Estimates

National and state

Contact Information

Agency home page: http://www.hrsa.gov. Accessed October 20, 2022.
Data system home page: https://bphc.hrsa.gov/datareporting/index.html. Accessed October 20, 2022.

For more details, refer to the UDS description documents available in the datasets and documentation section at: https://bphc.hrsa.gov/datareporting/index.html. Accessed October 20, 2022.

INDIAN HEALTH SERVICE

National Data Warehouse (NDW)

Sponsor

U.S. Department of Health and Human Services, Indian Health Service.

Description

The National Data Warehouse (NDW) is the national repository for all IHS healthcare data and includes information on patient registration and visit encounters. Data are derived from various government (Resource Patient Management System or "RPMS") and commercial healthcare information systems. These are largely transaction-based systems used to support patient care. NDW was upgraded from the National Patient Information Reporting System (NPIRS) in 2006.

Primary Content

NDW includes registration records and all encounter records (dated October 1, 2000, to the present). Registration tables contain patient information, including name, demographic data, medical chart data, aliases, and insurance eligibility data. Encounter tables contain encounter information, including location of treatment, clinic, provider, medications, and diagnosis codes.

Population Targeted

Approximately 1.7 million American Indian and Alaska Native people who belong to 574 federally recognized tribes in 37 states

Demographic Data

Age, gender, and American Indian and Alaska Native status

Years Collected

2001 to present

Data Collection Schedule

Daily

Geographic Estimates

National IHS service area estimates are available for the following Indian Health Service regions: Alaska, Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Tucson (excluding the Portland and California service areas where no IHS direct care inpatient facilities exist as of this writing)

Notes

In the calculation of NHQDR indicators based on populations, service population is used as the denominator. The service population estimates are based on official U.S. Census Bureau county data, representing self-identified AI/AN people who may or may not use IHS services.

In the calculation of indicators based on hospitalization, since no IHS inpatient facilities are in either the Portland or California service areas, and hospitalizations from these regions are not present in the data; the denominator is correspondingly reduced.

Contact Information

Agency home page: https://www.ihs.gov. Accessed October 20, 2022.
Data system home page: https://www.ihs.gov/dfo/systems/. Accessed October 20, 2022.

Division of Program Statistics home page: https://www.ihs.gov/DPS. Accessed October 20, 2022.

References

Indian Health Service Division of Program Statistics Website. Trends in Indian Health, p. 13. https://www.ihs.gov/dps/publications/trends2014/. Accessed October 20, 2022.

Resource and Patient Management System (RPMS) and National Patient Information Reporting System (NPIRS) in Data on Health and Well-being of American Indians, Alaska Natives, and Other Native Americans, Data Catalog. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/hsp/06/catalog-ai-an-na/RPMS.htm. Accessed October 20, 2022.

NATIONAL INSTITUTES OF HEALTH (NIH)

United States Renal Data System (USRDS)

Sponsor

Funding for the USRDS is provided by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health, U.S. Department of Health and Human Services, under contract with the University of Michigan. The Centers for Medicare & Medicaid Services (CMS) partners with NIDDK in supporting the USRDS.

Description

The USRDS is a national data system that maintains a relational database of diagnostic and demographic characteristics of end-stage renal disease (ESRD) patients. It includes information on the incidence, prevalence, morbidity, and mortality of this population, as well as biochemical lab results, dialysis and other institutional claims, physician/supplier services, treatment histories (useful for modality determination), and payer histories, hospitalization and modality events, and details regarding providers. As the ESRD population typically includes Medicare beneficiaries, the main data source for this database is CMS.

These CMS-supplied data are supplemented by data from the Social Security Administration, Organ Procurement and Transplant Network Transplant Database, U.S. Census Bureau, local and national ESRD provider databases, international ESRD registries, and CROWNWeb (a web-based data collection system that captures clinical and administrative data from Medicare-certified dialysis facilities for all ESRD patients). Thus, the USRDS database contains demographic, diagnostic, and treatment history information for all patients with ESRD, regardless of whether they are Medicare beneficiaries.

Primary Content

Date of onset of ESRD, treatment modality, causes of death, patient survival, hospitalization, cost and cost-effectiveness, and institutional providers of ESRD treatment. Special surveys cover behavioral risk factors, preventive health measures, health status, activity limitations, and healthcare access and utilization

Population Targeted

ESRD patients

Demographic Data

Gender, age, race, and ethnicity

Years Collected

Continuously since 1988

Data Collection Schedule

Annual

Geographic Estimates

National, state, and county

Contact Information

Agency home page: https://www.niddk.nih.gov. Accessed October 20, 2022.
Data system home page: https://www.usrds.org. Accessed October 20, 2022.

References

United States Renal Data System. 2016 USRDS Annual Data Report: Epidemiology of Kidney Disease in the United States. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2016.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

National Survey on Drug Use and Health (NSDUH)

Sponsor

The National Survey on Drug Use and Health (NSDUH) is sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality (CBHSQ).

Description

NSDUH, conducted annually by SAMHSA, provides nationally representative data on use of tobacco, alcohol, and illicit drugs; substance use disorders; receipt of substance use treatment; mental health issues; and use of mental health services among the civilian noninstitutionalized population age 12 and over in the United States.

Survey Sample Design

NSDUH covers residents of households (living in houses/townhouses, apartments, condominiums, etc.), people in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory workers' camps, halfway houses), and civilians living on military bases. The survey excludes homeless people who do not use shelters, active military personnel, and residents of institutional group quarters.

NSDUH data are representative of the nation and states. The survey design includes an independent, multistage area probability sample for each state and the District of Columbia to accommodate state estimates of substance use and mental health. The survey design also oversamples youths and young adults.

Primary Survey Content

NSDUH collects a respondent's demographic characteristics; age at first use, lifetime, past-year, and past-month use of the following substances: illicit drugs (marijuana or hashish, cocaine [including crack], inhalants, hallucinogens, heroin, or prescription-type psychotherapeutics used nonmedically [e.g., stimulants, sedatives, tranquilizers, and pain relievers]), alcohol, and tobacco; substance use disorders; substance use treatment; healthcare; mental health disorders; and mental health service utilization.

Population Targeted

U.S. civilian noninstitutionalized population age 12 and over

Demographic Data

Age, gender, race/ethnicity, marital status, education, employment status, family income, health insurance, veteran status, current household composition, and metropolitan status of county

Years Collected

Since 1971

Data Collection Schedule

Annual

Geographic Estimates

National, state, and substate, as well as county type and region

Notes

Public-use data files for 1979, 1982, 1985, 1988, and annually from 1990 to present are currently available through the Substance Abuse and Mental Health Data Archive (SAMHDA) and the archive's online data analysis system (https://www.datafiles.samhsa.gov/). Data from the 2020 NSDUH should not be compared with prior years due to methodological changes.

Contact Information

Agency home page: https://www.samhsa.gov. Accessed October 20, 2022.
Data system home page: https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health. Accessed October 20, 2022.

References

Center for Behavioral Health Statistics and Quality. Key Substance Use and Mental Health Indicators in the United States: Results From the 2020 National Survey on Drug Use and Health, NSDUH Series H-56, HHS Publication No. PEP21-07-01-003. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2021. https://www.samhsa.gov/data. Accessed October 19, 2022.

Substance Use Disorder Treatment Episode Data Set (TEDS)

Sponsor

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality.

Description

TEDS is an admission-based system and is part of SAMHSA's Behavioral Health Services Information System. TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to substance abuse treatment. The data are routinely collected by state administrative systems and then submitted to SAMHSA in a standard format.

TEDS does not include all admissions to substance abuse treatment. It includes admissions to facilities that are licensed or certified or funded by the state substance abuse agency to provide substance abuse treatment (or are administratively tracked by the agency for other reasons). TEDS does not include data from facilities operated by federal agencies. The scope of facilities included in TEDS may differ from state to state due to differences in state systems of licensure, certification, accreditation, and funds disbursement.

When undergoing substance abuse treatment, individual people can be admitted and discharged from treatment multiple times. TEDS comprises demographic and drug history information about

these individuals. TEDS-A records the admissions, and TEDS-D records the discharges. The two datasets are separate but linkable. TEDS-A data collection began in 1992, and TEDS-D began in 2000. These datasets include:

- Data for individuals age 12 years and over.
- Records for an admission or discharge, not individual people.
- Demographic information, such as age, sex, race/ethnicity, and employment status.
- Substance abuse characteristics, such as substances used, age at first use, route of use, frequency of use, and number of previous admissions.

Primary Content

Patient demographics; primary, secondary, and tertiary substance; length of stay; reason for discharge.

Population Targeted

Admissions to publicly funded substance abuse treatment facilities

Demographic Data

Age, gender, race, ethnicity, and education

Years Collected

Since 1992

Schedule

Monthly or quarterly submissions from states; annual report

Geographic Estimates

National and state

Contact Information

Agency home page: http://www.samhsa.gov. Accessed October 20, 2022.
Data system home page: http://samhsa.gov/data/. Accessed October 20, 2022.

UNITED STATES CENSUS BUREAU

American Community Survey (ACS)

Sponsor

The United States Census Bureau, a part of the U.S. Department of Commerce

Description

The American Community Survey (ACS) is an ongoing survey that provides vital information on a yearly basis about our nation and its people. Information from the survey generates data that help determine how more than $675 billion in federal and state funds are distributed each year.

ACS provides information about jobs and occupations, educational attainment, veterans, home ownership, and other topics. Data users include public officials, planners, and entrepreneurs. ACS data inform efforts to plan for hospitals and schools, support school lunch programs, improve emergency services, and inform businesses looking to add jobs and expand to new markets.

Survey Sample Design

ACS forms are not mailed to specific people, but rather to specific addresses. The sample is designed to ensure good geographic coverage and does not target individuals. By focusing on quality geographic coverage, ACS can produce a good picture of the community's people and housing by surveying a representative sample of the population.

The Census Bureau selects a random sample of addresses to include in ACS. Each address has about a 1-in-480 chance of being selected in a month, and no address should be selected more than once every 5 years.

The Census Bureau mails questionnaires to approximately 295,000 addresses each month across the United States. This is a small percentage of the more than 140 million eligible addresses in the United States, and an address that receives ACS instructions will not likely find a neighbor or friend who has also received them.

Responses to the American Community Survey are collected in four different ways: internet, mail, telephone, and in-person interviews.

Primary Survey Content

ACS is a nationwide, continuous survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. Since its start, it has been providing a continuous stream of updated information for states and local areas and has helped revolutionize the way people use statistics to understand communities.

From 1970 to 2000, short- and long-form questionnaires were distributed by the Census Bureau. Most households received the short-form, which included only basic questions such as those about age, sex, race, ethnicity, and household characteristics. A small portion of households received the long-form, which collected additional population and housing characteristics. After

the 2000 Census, however, the long form became ACS, and this survey continues to collect long-form information each year.

Responses are combined and statistics are published for communities nationwide. The results are then used by community and local governments and the private sector. ACS estimates are often used to help establish priorities through needs assessments, to develop general plans for communities, for research and education, and for advocacy work.

Population Targeted

Civilian population residing in the United States

Demographic Data

Gender, age, race/ethnicity, education, income, marital status, place of birth, industry, and occupation

Years Collected

2006 to present

Data Collection Schedule

Annual

Geographic Estimates

National and state

Contact Information

Agency home page: https://www.census.gov/. Accessed October 20, 2022.
Data system home page: https://www.census.gov/programs-surveys/acs/about.html. Accessed October 20, 2022.

References

For more details, refer to the ACS document available at https://www.census.gov/content/dam/Census/programs-surveys/acs/about/ACS_Information_Guide.pdf. Accessed October 20, 2022.

ACADEMIC INSTITUTIONS

University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)

Sponsor

University of Michigan with funding from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS)

Description

UM-KECC is an interdisciplinary research group drawing from the Departments of Biostatistics, Health Management and Policy, Surgery, and Nephrology. UM-KECC carries out epidemiologic, clinical, medical outcomes, public policy, and economic research related to end stage renal disease (ESRD), chronic kidney disease (CKD), and organ transplantation.

UM-KECC maintains comprehensive historic patient- and provider-level data on more than 2 million ESRD patients. Data are derived from an extensive national ESRD patient database, which is primarily based on the CMS Consolidated Renal Operations in a Web-enabled Network (CROWN) system. CROWN data include the Renal Management Information System, CROWNWeb facility-reported clinical and administrative data (including CMS-2728 Medical Evidence Form, CMS-2746 Death Notification Form, CMS-2744 Annual Facility Survey Form data, and vascular access information).

Other data sources include Medicare dialysis and hospital payment records; transplant data from the Organ Procurement and Transplant Network and the Scientific Registry of Transplant Recipients; the Nursing Home Minimum Data Set (MDS); and the Quality Improvement Evaluation System Business Intelligence Center, which includes data from the Certification and Survey Provider Enhanced Report System.

The database is comprehensive for Medicare patients. Non-Medicare patients are included in all sources except the Medicare payment records. CROWNWeb provides tracking by dialysis provider and treatment modality for non-Medicare patients.

Primary Content

Data include information about directly actionable practice patterns such as dose of dialysis, vascular access, and anemia management and patient outcomes (mortality, hospitalization, and transplantation) that can be used to inform and motivate reviews of practices.

The information in the report facilitates comparisons of facility data to local and national averages. Available data include patient characteristics (laboratory values, primary cause of ESRD, comorbidities), treatment patterns (dialytic modality, hemoglobin levels, Kt/V), and outcomes (transplantation, wait list, hospitalization, mortality). Facility information provides counts of patients treated, Medicare eligibility, treatment modality, staffing, survey and certification activity, and services provided.

Population Targeted

ESRD patients in the United States

Demographic Data

Age, gender, race, ethnicity, and state of residence

Years Collected

1999 to present.

Data Collection Schedule

Annually each July.

Geographic Estimates

National, state, network, and regional levels.

Notes

See entry for United States Renal Data System for information on prior years of data collection.

Contact Information

Organization home page: https://medicine.umich.edu/dept/intmed/divisions/nephrology/research/u-m-kidney-epidemiology-cost-center. Accessed October 20, 2022.
Data system home page: https://www.dialysisdata.org. Accessed October 20, 2022.

References

UM-KECC. Methodology documents. https://dialysisdata.org/content/dialysis-facility-report-methodology. Accessed October 20, 2022.

PROFESSIONAL ORGANIZATIONS AND ASSOCIATIONS

American Hospital Association, Information Technology Supplement

Sponsor

American Hospital Association (AHA)

Description

The AHA conducts an annual survey of all hospitals in the United States, including both registered and nonregistered hospitals. The focus is on four main areas: organization, facilities, community benefit, and utilization. Since 2008, the AHA, in collaboration with the Department of Health and Human Services, Office of the National Coordinator, administers a supplemental, Information Technology (IT) mail survey to gather information on the extent to which hospitals have fully functional health information systems, the characteristics of these systems and the functions available, and use by hospital staff.

Survey Sample Design

The 2020 survey for the IT Supplement was sent to 6,093 nonfederal acute care hospitals in the United States, including non-AHA member hospitals. The survey was in the field from February 2021 to July 2021. The response rate was 46.9%. If data are missing, the hospital is not included in the numerator or denominator of generated statistics.

Primary Survey Content

The full AHA Hospital Survey reports on statistics including current and historical data on utilization, personnel, revenue, expenses, managed care contracts, community health indicators, physician models, technology, electronic record system, number of beds and admissions, and urban/rural status. The 2020 IT supplement queries hospital representatives about the adoption of electronic medical records and the scope of computer functionalities used by the facility.

Population Targeted

All hospitals in the United States.

Demographic Data

Combined with the core survey, information collected includes identifying information about the hospitals, organizational structure, facilities and services, utilization data, community orientation indicators, physician arrangements, managed care relationships, expenses, staffing, use of electronic medical records, and use of electronic systems for prescribing and sharing patient information across providers.

Years Collected

Since 2008

Data Collection Schedule

Annual

Geographic Estimates

National and regional

Contact Information

Agency home page: https://www.aha.org/. Accessed September 7, 2022.

References

Wolf L, Harvell J, Jha AK. Hospitals ineligible for federal meaningful-use incentives have dismally low rate of adoption of electronic health records. Health Aff 2012;31(3):505-13.

National Cancer Data Base (NCDB)

Sponsor

Operation of the NCDB is jointly supported by the Commission on Cancer (CoC) of the American College of Surgeons and the American Cancer Society.

Description

NCDB is a nationwide facility-based oncology database that annually captures 70% of all newly diagnosed cancer cases in the United States. NCDB holds information on more than 29 million cases of reported cancer diagnoses since 1985 and continues to grow.

All CoC-accredited hospital cancer programs are annually required to submit data for all patients diagnosed or treated for a cancer diagnosis. More than 1,500 participating hospitals respond to a call for data, submitting case reports for a specified calendar year approximately 9 months after the calendar year.

CoC-accredited cancer program registries collect and submit data elements to the NCDB using nationally standardized data item and coding definitions. These are found in CoC's Facility Oncology Registry Data Standards (FORDS) and the North American Association of Central Cancer Registries' nationally standardized data transmission format specifications

Primary Content

The NCDB contains standardized data elements on patient demographics, patient insurance status, tumor site, stage and morphology, comorbidities, first course of treatment, disease recurrence, and survival information. In addition, NCDB contains information on patient ZIP Code and county of residence, which are used to incorporate area-based sociodemographic characteristics. Selected characteristics of the reporting healthcare facility are also collected.

Population Targeted

Cancer patients in the United States

Demographic Data

Gender, age at cancer diagnosis, and race/ethnicity

Years Collected

Continuously since 1985

Data Collection Schedule

Annual

Geographic Estimates

National; nine U.S. Census Bureau regions; metropolitan and nonmetropolitan areas

Contact Information

NCDB home page: http://www.facs.org/quality-programs/cancer-programs/national-cancer-database. Accessed August 30, 2022.

References

Bilimoria KY, Stewart AK, Winchester DP, et al. The National Cancer Data Base: a powerful initiative to improve cancer care in America. Ann Surg Oncol 2008 Mar; 15(3):683-90. Epub 2008 Jan 9.

Stewart AK, Bland KI, McGinnis LS, et al. Clinical highlights from the National Cancer Data Base. CA Cancer J Clin 2000; 50:171-83.

Sylvester J, Blankenship C, Carter A, et al. Quality control: the American College of Surgeons Commission on Cancer Standards, National Cancer Data Base, and Cancer Liaison Program. J Reg Mgmt 2000; 27:68-74.

MULTIPLE-SOURCE DATA SPONSORS

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

The MEPS Household Component (HC), the core survey, is an interviewer-administered computer-assisted personal interview household survey. The Self-Administered Questionnaire (SAQ) and Diabetes Care Survey (DCS) are supplementary self-administered paper questionnaires.

Survey Sample Design

The sampling frame for the MEPS-HC is drawn from respondents to the National Health Interview Survey (NHIS), conducted by NCHS. The MEPS-HC augments NHIS by selecting a sample of NHIS respondents, collecting additional data on their healthcare expenditures, and linking these data with additional information from the respondents' medical providers, employers, and insurance providers.

Each year a new panel of households is selected from among those households that participated in the previous year's NHIS. Data covering 2 calendar years of information are collected for each new annual sample (referred to as a panel), through a series of five rounds of data collection over a 2½-year period. This series of data collection activities is repeated each year on a new sample of households, resulting in overlapping panels of survey data. MEPS annual data are based on information from two separate panels, the panel that began that year and the panel that began in the previous year.

NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population, with oversampling of Hispanic and Black populations. Starting in 2006, NHIS oversamples Asian populations as well. In addition to the oversampling by NHIS, MEPS oversamples policy-relevant groups such as low-income households.

The MEPS instrument design changed beginning in spring 2018, affecting Panel 23 Round 1, Panel 22 Round 3, and Panel 21 Round 5. For the Full-Year 2017 public use files (PUFs), the Panel 22 Round 3 and Panel 21 Round 5 data were transformed to the degree possible to conform to the previous design.

The Full-Year 2018 PUFs was the first year that all rounds of data were collected with the redesigned instrument, and no data were transformed to conform to the previous design. Data users should be aware of possible effects on the data and especially trend analysis for these data years due to the design transition.

Primary Survey Content

MEPS consists of three component surveys: the HC, the Medical Provider Component, and the Insurance Component. The MEPS-HC collects detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. The data for the NHQDR and NHDR are primarily from the following sections of the 2002-2019 MEPS-HC:

- SAQ: This paper questionnaire collects data on a variety of adult health and healthcare quality measures.
- DCS: This paper questionnaire, given to people identified as ever having had diabetes, asks about their diabetes care, such as services rendered.
- Child Health and Preventive Care (CHPR) section: Starting in 2001, the CHPR section was added to the MEPS-HC interviews during the second half of the year. It included healthcare quality measures taken from the health plan version of CAHPS® (Consumer Assessment of Healthcare Providers and Systems); the Children With Special Health Care Needs screener questions; children's general health status as measured by several questions from the General Health Subscale of the Child Health Questionnaire; Columbia Impairment Scale questions about possible child behavioral problems; and child preventive care questions. Before 2001, the CAHPS questions and the Children with Special Health Care Needs screener questions had been in the Parent-Administered Questionnaire. Therefore, estimates from 2001 may not be comparable with estimates for 2000 or earlier years.
- Access to Care: The Access to Care section of the MEPS-HC gathers information on five main topic areas: family members' origins and preferred languages; family members' usual source of healthcare; characteristics of usual source of healthcare providers; satisfaction with and access to the usual source of healthcare provider; and access to medical treatment, dental treatment, and prescription medicines.
- Preventive Care: For each person, a series of questions was asked primarily about the receipt of preventive care or screening examinations.

Population Targeted

Like the NHIS population from which its sample is drawn, the MEPS-HC is a nationally representative survey of the U.S. civilian noninstitutionalized population.

Demographic Data

The MEPS-HC collects data on demographic characteristics, including age, gender, race, ethnicity, education, industry and occupation, employment status, household composition, and family income. Race and ethnicity variables and categories changed in 2002 in compliance with Office of Management and Budget standards.

Years Collected

MEPS is the third in a series of national probability surveys conducted by AHRQ on the financing and use of medical care in the United States. The National Medical Care Expenditure Survey was conducted in 1977, the National Medical Expenditure Survey was conducted in 1987, and MEPS, an annual survey, began in 1996.

Data Collection Schedule

Annual

Geographic Estimates

National; four U.S. Census Bureau regions; selected States; metropolitan and nonmetropolitan areas; and urban-rural areas, based on frameworks such as the 2006 and 2013 Urban-Rural Classification Scheme for Counties (https://www.cdc.gov/nchs/data_access/urban_rural.htm; accessed October 20, 2022)

Notes

Estimates in the NHQDR data tables that are based on MEPS data are weighted to reflect the experiences of the U.S. civilian noninstitutionalized population. Standard errors of the estimates were derived using SUDAAN statistical software, which factors in MEPS complex survey design. MEPS estimates are suppressed when they are based on sample sizes of fewer than 100, or when their relative standard errors are 30% or more.

The combined response rate for MEPS, which includes the NHIS response rate, ranged from 42% to 65% during the 2002 to 2018 period.

Contact Information

Agency home page: https://www.ahrq.gov. Accessed October 20, 2022.
Data system home page: https://www.meps.ahrq.gov/. Accessed October 20, 2022.

References

Cohen J. Design and methods of the Medical Expenditure Panel Survey Household Component. MEPS Methodology Report No. 1. Rockville, MD: Agency for Health Care Policy and Research; 1997. AHCPR Publication No. 97-0026. https://www.meps.ahrq.gov/mepsweb/data_files/publications/mr1/mr1.pdf. Accessed October 20, 2022.

Cohen JW, Monheit AC, Beauregard KM, et al. The Medical Expenditure Panel Survey: a national health information resource. Inquiry 1996/1997; 33:373-89. Rockville, MD: Agency for Health Care Policy and Research; 1997. AHCPR Publication No. 97-R043. https://www.meps.ahrq.gov/mepsweb/data_stats/Pub_ProdResults_Details.jsp?pt=Journal+Articles&opt=3&id=324. Accessed October 20, 2022.

Cohen S. Sample design of the 1996 Medical Expenditure Panel Survey Household Component. MEPS Methodology Report No. 2. Rockville, MD: Agency for Health Care Policy and Research; 1997. AHCPR Publication No. 97-0027. https://www.meps.ahrq.gov/mepsweb/data_files/publications/mr2/mr2.pdf. Accessed October 20, 2022.

Cohen SB. Sample design of the 1997 Medical Expenditure Panel Survey Household Component. MEPS Methodology Report No. 11. Rockville, MD: Agency for Healthcare Research and Quality; 2000. AHRQ Publication No. 01-0001. https://www.meps.ahrq.gov/mepsweb/data_files/publications/mr11/mr11.pdf. Accessed October 20, 2022.

Ezzati-Rice TM, Rohde F, Greenblatt J. Sample design of the Medical Expenditure Panel Survey Household Component, 1998-2007. MEPS Methodology Report No. 22. Rockville, MD: Agency for Healthcare Research and Quality; March 2008. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr22/mr22.pdf. Accessed October 20, 2022.

Chowdhury SR, Machlin SR, Gwet KL. Sample Designs of the Medical Expenditure Panel Survey Household Component, 1996-2006 and 2007-2016. Methodology Report 33. Rockville, MD: Agency for Health Care Policy and Research; 2019. https://meps.ahrq.gov/data_files/publications/mr33/mr33.pdf. Accessed October 20, 2022.

Quality and Safety Review System (QSRS)

Sponsor

AHRQ is implementing QSRS, an improved patient safety surveillance system designed to replace the Medicare Patient Safety Monitoring System (MPSMS) for measurement and trending of adverse event rates among hospitalized patients in the United States. The Centers for Medicare & Medicaid Services (CMS) supports this project by designing sample strategies annually and requesting, acquiring, and storing medical charts for inclusion.

Description

QSRS relies on clinical information recorded in medical records and is designed to use structured data where they are or may become available. The use of reliable structured data, such as medication prescriptions and laboratory test results that are relevant to patient safety events, offers opportunities to further enhance QSRS efficiency. Overall, QSRS will generate adverse event rates and trend national performance over time.

From 2017 through 2019, QSRS used the same sample as MPSMS that was drawn from a national sample from the CMS Inpatient Quality Reporting (IQR) program. For many years, MPSMS represented hospital admissions for one or more of four conditions: heart failure, acute myocardial infarction, pneumonia, or a major surgical procedure.

The IQR measures associated with the Four-Condition sample were retired in 2015. However, to maintain consistency for trending, those same all payer Four-Condition charts were drawn from the Global, or All-Other Conditions, sample representing all hospital discharges. From 2017 through 2019, the QSRS sample used the same Four-Condition and All-Other Conditions charts used in the MPSMS sample. As of 2020, the QSRS sample includes Medicare patients discharged with all diagnoses.

Primary Content

QSRS is designed to facilitate improvements in patient safety by fostering an understanding of the magnitude of specific patient safety issues associated with the processes of hospital care. Table 1 lists adverse event categories monitored by QSRS. QSRS also collects and examines patient risk factors, such as demographics and secondary diagnoses, as well as data on outcomes, such as length of hospital stay and in-hospital mortality.

Table 1. Measures and modules included in calculation of adverse event rates

Measure	Module
One or more adverse outcomes related to receipt of blood or blood product transfusion	Blood and Blood Product
One or more maternal adverse outcomes	Birth - Maternal
Adverse event associated with hypoglycemic agent	Medication
Adverse event associated with IV unfractionated heparin	Medication
Adverse event associated with low molecular weight heparin, thrombin inhibitor, or factor Xa inhibitor	Medication
Adverse event associated with warfarin	Medication
Adverse event within 24 hrs. following opioid administration*	Medication
Anaphylaxis	Medication
Possible overdose	Medication
Coronavirus (COVID-19)	Healthcare-Associated Infection
Central line-associated bloodstream infections	Healthcare-Associated Infection
Urinary tract infections	Healthcare-Associated Infection
Catheter-associated urinary tract infection	Healthcare-Associated Infection
Clostridium difficile infection acquired during stay	Healthcare-Associated Infection
Hospital-acquired pneumonia not related to surgical procedure	Healthcare-Associated Infection
Hospital-acquired pneumonia preceded by major surgical procedure	Healthcare-Associated Infection
Surgical site infection following operating room procedures	Healthcare-associated Infection
Patients with one or more falls during stay	Fall
Stays with one or more pressure ulcer adverse events	Pressure Ulcer
Venous thromboembolism/pulmonary embolism (VTE/PE) not related to procedure	Venous Thromboembolism
VTE/PE following listed procedure (no VTE prior to procedure)	Venous Thromboembolism
One or more adverse outcomes from one or more operating room procedures or instance of anesthesia during stay	Surgery or Anesthesia
Iatrogenic pneumothorax	Other Outcomes of Interest
Unintended laceration or puncture	Other Outcomes of Interest
Adverse outcome from arterial puncture	Other Outcomes of Interest
Mechanical adverse event associated with central venous catheter	Other Outcomes of Interest
Burn during stay	Other Outcomes of Interest
Patient attempted suicide during stay	Other Outcomes of Interest
Harm from use of physical restraint (other than bedrails)	Other Outcomes of Interest
Harm from accident associated with bedrails (other than fall)	Other Outcomes of Interest
Intravascular air embolism during stay	Other Outcomes of Interest
Patient elopement during stay	Other Outcomes of Interest

Population Targeted

All Medicare patients

Demographic Data

Age, race/ethnicity, gender, and payment source

Years Collected

2017-2020

Data Collection Schedule

Submitted and collected in real time and reported to AHRQ quarterly and annually

Geographic Estimates

National

Notes

In response to the 2019 Novel Coronavirus (COVID-19) pandemic, the CMS granted exemptions to the current Medicare quality reporting requirements and value-based purchasing program requirements for Quarter 1 and Quarter 2 2020. Because provider participation in Q1 and Q2 2020 was voluntary and results were not publicly reported, the NHQDR tables using 2020 CMS QSRS data are based on Q4 2020 only.

Contact Information

Agency home page: https://www.ahrq.gov and https://www.cms.gov. Accessed October 20, 2022.
Data system home page: https://www.ahrq.gov/patient-safety/quality-measures/qsrs/index.html. Accessed October 20, 2022.