Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
Behavioral Risk Factor Surveillance Survey (BRFSS)	In 1984, the Centers for Disease Control and Prevention (CDC) initiated the state-based Behavioral Risk Factor Surveillance System (BRFSS)--a cross-sectional telephone survey that state health departments conduct monthly over landline telephones and cellular telephones with a standardized questionnaire and technical and methodologic assistance from CDC. BRFSS is used to collect prevalence data among adult U.S. residents regarding their risk behaviors and preventive health practices that can affect their health status. Respondent data are forwarded to CDC to be aggregated for each state, returned with standard tabulations, and published at year's end by each state. BRFSS now collects data in all 50 states as well as the District of Columbia and three 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.	The BRFSS Data User Guide is intended to provide a brief overview of BRFSS to data users https://www.cdc.gov/brfss/data_documentation/pdf/userguidejune2013.pdf. Specific information regarding data quality, response and/or cooperation rates, or calling outcome can be found in the Summary Data Quality Report produced each year in conjunction with the annual data release. Data users needing more information about comparability across years should refer to the annual Comparability of Data document, particularly before using the data to conduct trend analyses.

From the 1980s to 2010, CDC has used a statistical method called post stratification to weight BRFSS survey data to known proportions of age, race and ethnicity, sex, geographic region within a population. In 2011 the BRFSS moved to a new weighting methodology known as iterative proportional fitting or raking. Raking has several advantages over post stratification. First, it allows the introduction of more demographic variables—such as education level, marital status, and home ownership—into the statistical weighting process than would have been possible with post stratification. This advantage reduces the potential for bias and increases the representativeness of estimates. Second, raking allows for the incorporation of a now-crucialvariable—telephone ownership (landline and/or cellular telephone)—into the BRFSS weighting methodology. Beginning with the 2011 dataset, raking succeeded post stratification as the BRFSS statistical weighting method. As noted in the previous paragraph, age, sex, categories of ethnicity, geographic regions within states, marital status, education level, home ownership and type of phone ownership are currently used to weight BRFSS data. | https://www.cdc.gov/brfss/ |
| Behavioral Risk Factor Surveillance Survey (BRFSS) Asthma Callback | The Asthma Call-back Survey (ACBS) is an in-depth asthma survey developed and funded by the Air Pollution and Respiratory Health Branch (APRHB) in the National Center for Environmental Health (NCEH). It is conducted with Behavioral Risk Factor Surveillance System Survey (BRFSS) respondents who report an asthma diagnosis. | Asthma surveillance data at the state level includes adult and child asthma prevalence from the Behavioral Risk Factor Surveillance System (BRFSS) and in-depth state and local asthma data through implementation of the BRFSS Asthma Call-back Survey (ACBS). | https://www.cdc.gov/brfss/acbs/index.htm |

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NH Hospital Discharge Data Set	All hospitals licensed by the New Hampshire Department of Health and Human Services (NH DHHS) under RSA He-C 151:2 are required by law to report patient-level discharge information to DHHS. Discharges are also collected from select rehabilitation hospitals, rehabilitation and psychiatric units within acute care hospitals, and free-standing ambulatory surgical treatment centers that are part of a hospital. A total number of 32 New Hampshire (NH) hospitals report hospital claim data to the State. The reporting facilities do not include non-emergency walk-in care centers (a.k.a. Urgent Care) which are not affiliated with the 32 reporting hospitals.	Inpatient and Emergency Department Acute Care Hospital Discharge data is collected under New Hampshire statute RSA 126:25 requiring all NH facilities to report discharge data to the NH Department of Health and Human Services. Records of discharges of NH residents that occurred in Massachusetts, Vermont, and Maine are obtained by the Department through interstate data exchange agreements with the agencies in those states responsible for collection of discharge data. Those agencies are the Center for Health Information and Analysis (CHIA) in Massachusetts, the Maine Health Data Organization, and the Vermont Department of Health. Discharge of NH residents from Maine, Massachusetts and Vermont hospitals are included in the dataset. Transfers of NH residents are also included in the dataset. Limitations: Discharges are not de-duplicated. Many patients return repeatedly to the hospital for services. Multiple admissions for one person might falsely elevate the number of persons hospitalized. Hospital inpatient discharges may include in-state and out-of-state hospitalizations for NH residents. Only MA, ME, and VT out-of-state hospitals are included. Encrypted social security number is not available for discharges from ME or VT. MA uses a different encryption key than NH for encrypted social security number. Discharges from the NH Veterans Administration Hospital, other military hospitals and special facilities are not in the NH UHDDS. Due to small state population, counts and age-adjusted rates may not be feasible to display at the county levels.	

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
NH Population	The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), Health Statistics & Informatics (HSI) developed NH population estimates for use in calculating health related rates by year, sex, and age for NH towns and Census Tracts. The population estimates start with the most recent decennial census data for the population estimate of the census year. Then each subsequent year the population is updated using the following data sources: Census PEP annual estimate by: year, county, sex, 5yr age-group to 85; NH Office of Strategic Initiatives (OSI) annual estimate of town total population; National Center for Health Statistics (NCHS) annual Bridged Race report by: year, county, sex, single year of age to 85+ and by year, U.S. national, sex, single year of age 86 to 100+; and Spatial boundaries of NH Towns and census tracts. Population estimates are calculated for NH towns and census tracts by sex and single-year of age to 100+. These estimates have also been aggregated up to 5yr age-groups to 85+, and can be rolled up by geography to county, regional public health network, hospital service area and other regional groupings of interest.		

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
NH State Cancer Registry (NHSCR)	The New Hampshire State Cancer Registry (NHSCR) is a statewide, population-based cancer surveillance program that collects incidence data on all cancer cases diagnosed or treated in the State of New Hampshire. Since its inception in 1985, the NHSCR has been contracted to Dartmouth Medical School by the DHHS Division of Public Health Services and the Health Statistics and Data Management Section.	The NHSCR collects incidence data on all cancer cases diagnosed or treated in New Hampshire. As required by the NH Administrative Rules, the NHSCR currently collects data from hospital registrars in the larger hospitals in NH. Hospitals with fewer than 105 cases per year that generally do not have their own cancer registry are assisted by NHSCR staff helps these hospitals with some of their reporting duties. NHSCR also receives case report from physician practices, free standing radiation oncology centers, pathology laboratories and other sources. In addition, the NHSCR receives case reports for NH residents who are diagnosed outside the state, based on interstate data exchange agreements.

The NHSCR has an innovative, two-phase reporting system. The initial rapid report provides basic aspects of case identification and is submitted within 45 days of diagnosis. A definitive case report is transmitted within 180 days from the date of diagnosis, and includes more detailed information, such as treatment and staging information. Timely reporting is essential for registry activities. | https://geiselmed.dartmouth.edu/nhscr/about/ |
| NH Vital Records Birth Certificate Data | The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), Health Statistics & Informatics (HSI): Receives access to birth datavia the Bureau of Data and Systems Management inDHHS from the Division of Vital Records Administration under NH state law; Analyzes information from reported birth records for NH DHHS programs and for external community customers; Works collaboratively and in partnershipwith the NH Birth Conditions Program to provide surveillance data on birth conditions; Distributes statistical reports to government agencies and otherrequesting public and private organizations; and Prepares reports that contain tabulations of birth data. | The Division of Vital Records Administration in the Office of the Secretary of State collects:
• NH Birth information from hospital and midwife reporters;
• NH resident out-of-state births through an interstate exchange agreement; and
• Birth certificate data information, which includes:
• Newborn's sex, weight, period of gestation, date of birth and congenital anomalies;
• Mother's and father's residence, age, race and ancestry; and
• Many characteristics of the pregnancy and birth including maternal smoking and alcohol use, method of delivery, use of prenatal care and complications of the pregnancy. | https://www.dhhs.state.nh.us/dphs/hsdm/birth/index.htm
https://sos.nh.gov/vital_records.aspx
https://nhvrinweb.sos.nh.gov/Default.aspx |

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
NH Vital Records Death Certificate Data	The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), Health Statistics & Informatics (HSI) receives access to death datavia the NH DHHS Bureau of Data & Systems Management from the NH Division of Vital Records Administration under NH state law; Analyzes information from the records of reported deaths forNH DHHS and external community customers; Prepares reports that contain tabulations of death data; and, Distributes statistical reports to government agencies and other requesting public and private organizations.	The NH Division of Vital Records Administration in the Office of the Secretary of State is responsible for collecting information on deaths of NH residents and deaths occurring in NH. Funeral home directors and the medical examiner report the information to the Division of Vital Records Administration. Information about NH resident out-of-state deaths is reported to NH through an interstate exchange agreement. This dataset is complete and available for analysis approximately 24-48 months after the close of a calendar year.	http://www.dhhs.state.nh.us/dphs/hsdm/death/index.htm http://sos.nh.gov/vital_records.aspx http://nhvrinweb.sos.nh.gov/Default.aspx

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
Pediatric Nutrition Surveillance System (PedNSS)	The Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Surveillance System (PNSS) are program-based surveillance systems that monitor the nutritional status of low-income infants, children, and women in federally funded maternal and child health programs. PedNSS data represent over 8 million children from birth to age 5. PNSS data represent approximately 1.3 million pregnant and postpartum women. These surveillance systems provide data that describe prevalence and trends of nutrition, health, and behavioral indicators for mothers and children.	Demographic data collected by PedNSS include race or ethnicity, sex, migrant status, household income (where indicated), and zip code. • Data collected to assess nutritional status include weight, length/height, and hemoglobin or hematocrit measurements. Weight, stature, and length are commonly used to assess the size and growth of children. • Data on birthweight and breastfeeding status are collected on children from birth to two years of age. • Health risk behavior data includes tv/video viewing and household smoking. Data is collected at the clinic level then aggregated at the state level and submitted to CDC for analysis. When multiple visit records are submitted for a child during the reporting period, CDC creates a unique child record following specific selection criteria that may contain some data from all available records. The CDC then calculates the nutrition-related indices and sends each contributor agency a series of annual tables that summarize the nutritional status and infant feeding practices by age of child and race/ethnicity. The national PedNSS tables are included in the Pediatric Data Tables section. Limitations of the PedNSS Data: PedNSS is a public health surveillance system based on data routinely collected from several federally funded public health programs serving low-income children. Contributors voluntarily participate in PedNSS. Not all contributors for a specific public health program participate in PedNSS. For example, not all states, U.S. territories, and tribal agencies that provide WIC services participate in PedNSS. Therefore, the national PedNSS report is not representative of all WIC programs. Similarly, PedNSS is not representative of all low-income children or children in the general population. It is representative of the population served by the public health program submitting the surveillance data. It is essential data for use in planning, implementing, monitoring, and evaluating the nutritional status of children served by a specific public health program.	http://www.cdc.gov/pednss/ http://www.cdc.gov/pednss/what_is/pednss/what_data.htm

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
Pregnancy Nutrition Surveillance System (PNSS)	The Pregnancy Nutrition Surveillance System (PNSS) is a public health surveillance system that monitors the prevalence of nutrition problems, behavioral risk factors, and birth outcomes among low-income women who are enrolled in public health programs in states, U.S. territories, or Indian Tribal Organizations (ITOs). The goal of the PNSS is to collect, analyze, and disseminate surveillance data to guide public health policy and action. The collected data are used to set public health priorities and to plan, implement, and evaluate nutrition programs for pregnant women.		https://www.cdc.gov/nccdphp/dnpao/
Pregnancy Risk Assessment Monitoring System (PRAMS)	The Pregnancy Risk Assessment Monitoring System is a joint research project between the state departments of health and the Centers for Disease Control and Prevention, Division of Reproductive Health. The Pregnancy Risk Assessment Monitoring System (PRAMS) was developed in 1987 to reduce infant morbidity and mortality by influencing maternal behaviors before, during, and immediately after pregnancy. It is the only surveillance system that provides data about pregnancy and the first few months after birth. PRAMS is an ongoing, state-specific, population-based surveillance system designed to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. New Hampshire joined the national effort and began data collection in 2013.		https://www.cdc.gov/PRAMS/index.htm

Data sources available for data request analysis

Source Dataset Name	Description	Methodology	References
Youth Risk Behavior Survey (YRBS)	The Youth Risk Behavior Surveillance System (YRBSS) was developed in 1990 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include behaviors that contribute to unintentional injuries and violence; sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity. In addition, the YRBSS monitors the prevalence of obesity and asthma and other priority health-related behaviors plus sexual identity and sex of sexual contacts. Indicator data is comprised from either Local Aggregate Sample or the Random Sample.	Starting from 1991, the YRBSS has collected data from more than 2.6 million high school students in more than 1,100 separate surveys. The YRBSS was designed to: • Determine the prevalence of health risk behaviors. • Assess whether health risk behaviors increase, decrease, or stay the same over time. • Examine the co-occurrence of health risk behaviors. • Provide comparable national, state, territorial, tribal, and local data. • Provide comparable data among subpopulations of youth. • Monitor progress toward achieving the Healthy People objectives and other program indicators Local Aggregate Sample The YRBSS includes national, state, territorial, tribal government, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States. The state, territorial, tribal government,and local surveys, conducted by departments of health and education, provide data representative of mostly public high school students in each jurisdiction. See Methodology of the Youth Risk Behavior Surveillance System—2013 for details about how the YRBS is conducted (https://www.cdc.gov/mmwr/pdf/rr/rr6201.pdf). Random Sample Youth Risk Behavior Surveillance System (YRBSS) Random Sample data are weighted to adjust for school and student nonresponse and to make the data representative of the population of students from which the sample was drawn. Generally, these adjustments are made by applying a weight based on student sex, grade, and race/ethnicity. Weighting is a mathematical procedure that makes data representative of the population from which it was drawn. In the YRBSS, only surveys with a scientifically drawn sample, appropriate documentation, and an overall response rate of at least 60% are weighted. State and local YRBS data that are weighted are representative of all public school students in grades 9-12 in the respective jurisdiction.	https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm https://www.cdc.gov/healthyyouth/data/yrbs/faq.htm