
APPENDIX H

HEALTH OUTCOME DATA CHECKLIST

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The following Checklist was developed to assist the Health Assessor in characterizing Health Outcome Data Sources at the federal, state, and local levels. A checklist needs to be completed for each data source identified for a site. Many of the variable will have yes or no (y/n) responses. The Health Assessor should note any deviations from the checklist. Definitions of terms used in the checklist are provided in the attached glossary.

Preparer's Name: _____

Date Prepared: _____

Site Name: _____

Site Address:

Street _____

City/Town _____

County _____

State _____

Primary Contact Person: _____

Agency/Affiliation: _____

Phone Number: _____

The following types of data forms are available and for what years																																			
<p>Report Form: Years Available:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Computerized _____ <input type="checkbox"/> Tape/cartridge _____ <input type="checkbox"/> Diskette _____ <input type="checkbox"/> Other _____ <p style="padding-left: 40px;">Specify _____</p> <p style="padding-left: 20px;">Please check all the variables available in the computerized data source, and for what years.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Data Variables:</td> <td style="width: 50%; border: none;">Years included:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Age</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Sex</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Ethnicity</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Address</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Diagnosis</td> <td style="border: none;">_____</td> </tr> </table>	Data Variables:	Years included:	<input type="checkbox"/> Age	_____	<input type="checkbox"/> Sex	_____	<input type="checkbox"/> Ethnicity	_____	<input type="checkbox"/> Address	_____	<input type="checkbox"/> Diagnosis	_____	<p>Report Form: Years included in data source:</p> <ul style="list-style-type: none"> Hard Copy _____ <input type="checkbox"/> Summary Report _____ <input type="checkbox"/> Other _____ <p style="padding-left: 40px;">Specify _____</p> <p style="padding-left: 20px;">Please check all the measures of effect reported in the hard-copy data, and for what years.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Measure of Effect:</td> <td style="width: 50%; border: none;">Years for which reported:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incidence</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Crude</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Age-adjusted</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Sex-Adjusted</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Race-Adjusted</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Odds Ratio</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Crude</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Age-Adjusted</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Sex-Adjusted</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Race-Adjusted</td> <td style="border: none;">_____</td> </tr> </table>	Measure of Effect:	Years for which reported:	<input type="checkbox"/> Incidence	_____	<input type="checkbox"/> Crude	_____	<input type="checkbox"/> Age-adjusted	_____	<input type="checkbox"/> Sex-Adjusted	_____	<input type="checkbox"/> Race-Adjusted	_____	<input type="checkbox"/> Odds Ratio	_____	<input type="checkbox"/> Crude	_____	<input type="checkbox"/> Age-Adjusted	_____	<input type="checkbox"/> Sex-Adjusted	_____	<input type="checkbox"/> Race-Adjusted	_____
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Who is the person (or organization) who reports the data to the data source?	What is the completeness of reporting by this person (organization)?
<ul style="list-style-type: none"> <input type="checkbox"/> Hospitals Specify: _____ <input type="checkbox"/> Private Physicians Specify: _____ <input type="checkbox"/> Laboratories Specify: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Complete <input type="checkbox"/> Partial <p style="padding-left: 40px;">Specify Percentage: _____</p>
<p>Are there any Confidentiality Issues for the data? Yes <input type="checkbox"/> or No <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify _____</p> <p style="padding-left: 20px;">_____</p>	

Contact Person: _____

Address/Affiliation: _____

Phone: _____

TYPE: STUDIES (Check One)

- Symptom/Disease Prevalence
- Exposure
- Cluster Investigation
- Analytic Studies

**** Please complete a separate form for each study, and obtain a copy of study proposal and findings.

<p>What is the geographic area included in the study?</p> <p>Specify: _____ _____ _____</p>	<p>Who is the Agency Responsible for Conducting the study (e.g. data collection)?</p>
<p>For what years were the data collected?</p> <p>Specify: _____ to _____</p>	<p><input type="checkbox"/> Federal Name: _____</p> <p>Who is the primary investigator for the study?</p> <p>Name: _____ Address/Affiliation: _____ Phone: _____</p> <p><input type="checkbox"/> State (include universities)</p> <p>Name: _____</p> <p>Who is the primary investigator for the study?</p> <p>Name: _____ Address/Affiliation: _____ Phone: _____</p> <p><input type="checkbox"/> Local</p> <p>Name: _____</p> <p>Who is the primary investigator for the study?</p> <p>Name: _____ Address/Affiliation: _____ Phone: _____</p>

Contact Person: _____

Address/Affiliation: _____

Phone: _____

TYPE: RECORDS (Checklist One)

- Medical (e.g. Hospital, Physician, ER Log)
- Educational (Attendance)
- Compliant (e.g. Air Pollution)
- Occupational Health

Agency Responsible for Reporting the data:	Agency Responsible for Maintaining the data?
<input type="checkbox"/> Federal Name: _____ Years data reported? _____ to _____ QA/QC documented for the data source? Yes <input type="checkbox"/> or No <input type="checkbox"/>	<input type="checkbox"/> Federal Name: _____ How frequently are the data updated? <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly
<input type="checkbox"/> State Name: _____ Years data reported? _____ to _____ QA/QC documented for the data source? Yes <input type="checkbox"/> or No <input type="checkbox"/>	<input type="checkbox"/> State Name: _____ How frequently are the data updated? <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly
<input type="checkbox"/> Local Name: _____ Years data reported? _____ to _____ QA/QC documented for the data source? Yes <input type="checkbox"/> or No <input type="checkbox"/>	<input type="checkbox"/> Local Name: _____ How frequently are the data updated? <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly

The following types of data forms are available and for what years?	For what geographic areas are the data available and for what years?	Who is the person (or organization) who reports the data to the data source?
Report Form: Years Available: <input type="checkbox"/> Computerized _____ <input type="checkbox"/> Tape/cartridge _____ <input type="checkbox"/> Diskette _____ <input type="checkbox"/> Other _____ Specify _____	Areas: Years Available: <input type="checkbox"/> Region _____ <input type="checkbox"/> State _____ <input type="checkbox"/> County _____ <input type="checkbox"/> City/Town/Twnshp _____ <input type="checkbox"/> Zip Code _____ <input type="checkbox"/> Census Tract _____ <input type="checkbox"/> Block, ED, BG _____	<input type="checkbox"/> Hospitals Specify: _____ <input type="checkbox"/> Private Physicians Specify: _____ <input type="checkbox"/> Laboratory Specify: _____
<input type="checkbox"/> Hard Copy _____ <input type="checkbox"/> Summary Report _____ <input type="checkbox"/> Other _____ Specify _____	Are there any Confidentiality Issues for the data? Yes <input type="checkbox"/> or No <input type="checkbox"/> Specify: _____ _____ _____	What is the completeness of reporting by this person or organization? <input type="checkbox"/> Complete <input type="checkbox"/> Partial Specify the percentage: ____

Please check all Data Variables included in the data source.	For what years are these variables available?
<input type="checkbox"/> Age <input type="checkbox"/> Sex <input type="checkbox"/> Ethnicity <input type="checkbox"/> Address	_____ _____ _____

COMPLETE THE APPROPRIATE BOX:		
Medical : Record Type: <input type="checkbox"/> Hospital Discharge <input type="checkbox"/> Physician's Records <input type="checkbox"/> Hospital Emergency Room Logs <input type="checkbox"/> Other: _____	Educational : Geographic Area covered by the data: <input type="checkbox"/> State <input type="checkbox"/> District Name: _____ <input type="checkbox"/> School Name: _____	Complaints: Type Specify: _____ Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Name of the facility responsible for preparing the Medical Record? _____ Address: _____	<input type="checkbox"/> Total Enrollment <input type="checkbox"/> Absentee Rates <input type="checkbox"/> Other Specify: _____ _____	What is the Geographic Area covered by the data? _____ _____
Please check which of the following data are available. <input type="checkbox"/> Diagnosis <input type="checkbox"/> Underlying Conditions <input type="checkbox"/> Risk Factors		Do the data indicate the type of follow-up provided for the complaints? Yes ___ or No ___

Contact Person: _____
 Address: _____
 Phone: _____