

Community Health Status Report: Data Sources, Definitions, and Notes

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COMMUNITY HEALTH STATUS REPORT: DATA SOURCES, DEFINITIONS, AND NOTES

This *Community Health Status Report: Data Sources, Definitions, and Notes*, referred to as the “companion document,” provides health indicator definitions, sources, and methods used in the Community Health Status Reports created by the Community Health Status Indicators (CHSI) Project. It is not intended to stand alone but to be used as a reference for the user of the county health profile provided for every U.S. county at: www.communityhealth.hrsa.gov.

The Community Health Status Report is a collection of nationally available indicators for counties representing several areas of responsibility for public health. While for many of the indicators there may be more than one method for calculating rates or percentages as well as more than one definition of the same problem, or source, the descriptions that follow are the choice made for this project and the means for ensuring that health measures for communities are consistent and not based on differing definitions or methodologies.

The estimates presented here rely on various data sources, methods, and calculations, some of which may not be appropriate for particular counties and/or purposes. Users should be aware of the limitations of these estimates. Those data that are estimated do not represent official Department of Health and Human Services statistics. We hope that the indicators provided in the CHSI Reports will be useful to communities and request feedback and comments.

DEMOGRAPHIC INFORMATION

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This section describes the context for county health — characteristics of a county's population that have a potential effect on the amount and type of services used, health status, and resources available.
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Data for Population Size, Poverty Level, Population by Age, and Population by Race/Ethnicity were obtained from the Current Population Survey (CPS) conducted by the U.S. Bureau of the Census. The CPS is an ongoing survey of states from which estimates for counties are derived. Due to the survey's small sample size, the confidence intervals for these measures may be wide and should be consulted when making comparisons to Peer Counties. Information on survey methodology and confidence intervals are found at: www.bls.census.gov/cps/tp/tp63.htm and www.bls.census.gov/cps/cpsmain.htm.

Population Size — This number is from “Estimates of the Population of Counties and Demographic Components of Population Change: Annual Time Series, July 1, 1990 to July 1, 1997” from the U.S. Bureau of the Census. The population figures are mid-year estimates for 1997 and are the source for calculations throughout the brochure.

Population Density — This number is calculated by using the following formula: 1997 Total Population Estimate / Land Area (square miles). Land Area is from the “County and City Data Book,” 1994, CD-ROM, a statistical abstract supplement published by the U.S. Bureau of the Census.

Poverty Level — The percentage of individuals living below the poverty level data in 1995 are from the U.S. Bureau of the Census' Small Area Income Poverty Estimates (SAIPE), U.S. Bureau of the Census at www.census.gov/hhes/poverty/threshld/thresh95.html.

Population by Age (1997) — Age-specific population sizes are from “Estimates of the Population of Counties by Age, Sex, Race, and Hispanic Origin: 1990 to 1997”, U.S. Bureau of the Census. These data are estimates of the resident population for mid-year 1997, U.S. Bureau of the Census.

Population by Race/Ethnicity — Race- and ethnicity-specific population sizes are from “Estimates of the Population of Counties by Age, Sex, Race, and Hispanic Origin: 1990 to 1997.” These data are mid-year estimates of the resident population, 1997, and reflect standard race and ethnicity categories in use by the U.S. Bureau of the Census.

FIPS Code (Federal Information Processing Standards) — These are standard codes, which indicate State and county, developed by the National Bureau of Standards. The combined State and county codes create a unique county identifier. The State portion of the code is a two-digit number, while the county portion consists of a three-digit number. In general, numbering is sequential when States and counties are listed alphabetically. Some cities in Hawaii and Virginia have been combined into their original counties. All counties in Alaska have been combined.

NOTE: Additional information about county and combined cities and counties is available from the Bureau of Health Professions, Health Resources and Services Administration, Area Resource File (ARF) System, (Fairfax, VA: Quality Resource Systems, Inc.) and its associated documentation (February 1999) and Web site www.hrsa.gov/bhpr/arf.htm and www.arfsys.com.

PEER COUNTIES

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A distinctive aspect of this report is the ability to compare a county with its peers, those counties similar in population composition and selected demographics. Comparison of a county to its peers is thought to take into account some of the factors that make a difference in a community's health.
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Strata, or peer groups, were developed with input from an advisory committee composed of Federal, State, and local public health professionals and members of academia. The project goal was to develop strata of 20-50 counties each, providing several peers for each county. The relatively large number in each stratum allows counties to choose a few peers that they believe to be most like them. The stratum size averages 35 and ranges from 14 to 58 counties. There are a total of 88 strata.

To define the strata, the following five factors were used:

- (1) Frontier status (The National Committee on Rural Health recommended classifying areas as frontier if they had fewer than 7 persons per square mile. Source: Popper, F.J. (1986) The strange case of the contemporary American frontier. *Yale Review*: 76(1); 101-121);
- (2) Population size, using the National Association of County and City Health Officials' population categories (less than 25,000; 25,000-49,999; 50,000-99,999; 100,000-249,999; 250,000-499,999; 500,000-999,999; 1,000,000 or more);

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- (3) Poverty quartiles (less than or equal to 10.55%; 10.56-14.15%; 14.16-19.25%; more than 19.26%), based on the percentage of individuals in the county living below the poverty level (e.g., in 1995 and for a family of four, the poverty level is \$15,569);
 - (4) Median age categories, based on the percentage of children (percentage of persons age<18 less than 26.13% or greater than or equal to 26.13%) and elderly (percentage of persons age 65+ less than or equal to 14.70% or greater than 14.70%) in the county; and
 - (5) Population density, as measured by half deciles (e.g., CHSI stratum 45 ranges between 42-157 persons per square mile).

Using an ordered, staged approach, counties were first grouped according to frontier status. Population size was used next. Then, as the number of counties in each category allowed, further groupings were made based on the remaining variables until the optimum stratum size was reached. Therefore, while all strata were classified according to the first two variables, only some were defined by factors of poverty, age, and population density. [A schematic of the stratification process is available at \[www.communityhealth.hrsa.gov\]\(http://www.communityhealth.hrsa.gov\).](#)

Each of the 88 strata is uniquely defined by two or more of the factors. It is possible that counties that are similar in several factors may not be in the same stratum due to category divisions.

The [Strata Listing](#) contains stratum by number and provides the number of counties and the ranges for population size, density, and poverty level for each. This table provides the characteristics of all strata and allows identification of other strata having similar characteristics. We encourage you to [view this table](#) to examine additional strata generated using this method and to explore other counties' reports.

This is the project's initial attempt at forming peer groupings of counties. Please feel free to comment at the Web site listed above to any of the CHSI partners on this process and its utility. Future reports may use different methods and/or criteria for determining strata.

SUMMARY MEASURES OF HEALTH

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These are broad measures of health. Each measure captures a single, comprehensive measure of population-based health but each provides only a single perspective. Four measures include the length of life (average life expectancy), the risk of dying (rates of death), and health-related quality of life (self-rated health status and average unhealthy days).

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NOTE: A ♥ indicates that the county's value is favorable when compared to the median value among peer counties or the US county median. A ☹ indicates that the county's value is unfavorable by comparison (i.e., higher than the median).

Average Life Expectancy — This represents the average number of years that a baby born in 1990 is expected to live if current mortality trends continue to apply. Calculations were made by Chris Murray and colleagues at the Harvard School of Public Health and were obtained from the Bureau of Primary Health Care, Health Resources and Services Administration. Deaths were from the Vital Statistics Reporting System, National Center for Health Statistics, 1985-94, and population data are from the U.S. Census Bureau, 1990. Methodology is described in the report, "US Patterns of Mortality by County and Race: 1965-1994" at www.hsph.harvard.edu/organizations/bdu/papers/usbodi/index.html. Estimates are based on national prevalence information and adjusted to reflect local demographic characteristics, therefore these estimates may not be accurate at the county level.

All Causes of Death — Mortality from any cause is the average annual rate of all causes of death, age-adjusted to the year 2000 Standard. Data are from the National Vital Statistics System, National Center for Health Statistics, 1997; Quality Resource Systems, Inc., Fairfax, VA, performed the age adjustment.

Self-rated Health Status — The percentage of adults, age 18 and older, who report "fair" or "poor" overall health is provided by the Behavioral Risk Factor Surveillance System (BRFSS), 1993-1997, a survey conducted jointly by States and the Centers for Disease Control and Prevention. County estimates were calculated by the Health Care and Aging Studies Branch, Centers for Disease Control and Prevention. Data are presented only for those counties with a survey sample size of 50 or greater. County-specific percentages were calculated using State weights, which may not be as accurate when county age-sex-race distributions differ substantially from that of the State. Due to small sample size, the confidence intervals for these data may be wide and should be consulted when making comparisons to Peer Counties because the variations observed may not be statistically valid.

Average Number of Unhealthy Days in Past Month — The average number of unhealthy days (mental or physical) in the past 30 days, reported by adults age 18 and older is provided, Behavioral Risk Factor Surveillance System (BRFSS), 1993-1997, a survey conducted jointly by States and the Centers for Disease Control and Prevention. County estimates were calculated by the Health Care and Aging Studies Branch, Centers for Disease

Control and Prevention. Data are presented only for those counties with a survey sample size of 50 or greater. County-specific percentages were calculated using State weights, which may not be as accurate when county age-sex-race distributions differ substantially from that of the State. Due to small sample size, the confidence intervals for these data may be wide and should be consulted when making comparisons to Peer Counties because the variations observed may not be statistically valid.

LEADING CAUSES OF DEATH

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Using major categories created by the National Center for Health Statistics, deaths by race or ethnicity and age group are reported and arranged in order of magnitude in which they occur nationally. Locally, the order of occurrence may vary.
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NOTE: Listed are the Nation’s leading causes of death for each age category. Depending upon county size, percentages for the most recent 3, 5, or 10 years are reported. However, county-specific data are only reported if there are at least 20 deaths in the age/race category, and the cause of death accounts for at least 10% of the deaths in the age/race category. The abbreviation “nrf” (not reported, few (events)) designates this occasion when no report is given because of too few events. Mortality data are from the Vital Statistics Reporting System, National Center for Health Statistics, 1988-1997, for the International Classification of Diseases (Ninth Edition) (ICD-9) codes after each variable, listed below. The ICD-9 codes in this report correspond to those used in the National Vital Statistics Reports from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention, and differ from the codes used in the death measures section.

ICD-9 Codes — The World Health Organization (WHO) maintains the *International Classification of Diseases (Ninth Edition)* (ICD-9) used widely in the health care field. These ICD-9 codes provide a worldwide standard for comparison of birth, death, and disease data. For more information, visit WHO’s Web site at: www.who.org/whosis/.

Complications of Pregnancy/Birth — Low birth weight, short gestation, complications of birth, respiratory conditions (e.g., respiratory distress syndrome, intrauterine hypoxia, and birth asphyxia), and other conditions at the time of birth. ICD-9 codes: 760-779.

Birth Defects — Congenital anomalies, ICD-9 codes: 740-759.

Injuries — Trauma from motor vehicle crashes and other sources, ICD-9 codes: E800-E949.

Homicide — Murder, ICD-9 codes: E960-E969.

Cancer — Malignant neoplasms, ICD-9 codes: 140-208.

Suicide — Death where one intentionally and voluntarily takes one's own life, ICD-9 codes: E950-E959.

Heart Disease — Any pathologic condition of the heart, ICD-9 codes: 390-398, 402, 404-429.

HIV/AIDS — NCHS codes: *042-*044. Note the asterisks before the category numbers indicate that they are not specified in the ICD-9.

Hispanic Ethnicity — This classification is a further description of persons already categorized by race. The reader is cautioned to use *either race or ethnicity* and not to treat the categories as mutually exclusive. Currently most States report ethnicity data, although this has not been the case in the past. This indicator is most complete for the most recent years.

MEASURES OF BIRTH AND DEATH

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Healthy People 2010 is a national health goal and objective setting activity led by the Office of Disease Prevention and Health Promotion and a compendium of health outcomes desired by the Year 2010. Achievable target levels for many health outcomes are provided. Many communities will be adopting or adapting these for local use. Healthy People 2010 target rates and 1997 U.S. rates are presented as a point of comparison for counties in assessing their current health status.

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NOTE: Annual death rates age-adjusted to the year 2000 standard were calculated by Quality Resource Systems, Inc. in Fairfax, VA. Mortality data are from the National Center for Health Statistics, Vital Statistics System, 1988-1997, for the ICD-9 codes listed after each variable. Population figures are from the U.S. Bureau of the Census. Depending upon county size and frontier status, the average annual age-adjusted rate for the most recent 3, 5, or 10 years is reported.

A 🍀 indicates that the county's value is favorable when compared with the median of the peer county range. A 🔍 indicates that the county's value is unfavorable by comparison (i.e., higher than the median).

Age Adjustment — This is a tool used to account for the changing age distribution of the population. Age adjustment enables counties with dissimilar populations (e.g., high percentage of elderly residents) to be compared. Age adjustment to the same standard population allows meaningful comparisons of vital rates over time and between groups.

Age-adjusted rates are based on the new, year 2000 standard. Use of the year 2000 standard has generally resulted in age-adjusted death rates that are substantially larger than those based on the 1940 standard. *Do not compare rates age-adjusted to year 2000 with rates age-adjusted to a different standard year (e.g., 1940).* For more information regarding age adjustment and the year 2000 standard, refer to Anderson, R. and Rosenberg, H., (October 7, 1998) “Age Standardization of Death Rates: Implementation of the Year 2000 Standard,” *National Vital Statistics Reports*, 47 (3). This publication can be obtained at the following internet address: www.cdc.gov/nchs/products/pubs/pubd/nvsr/47-pre/47-pre.htm.

County Percent or Rate — Each county-specific health indicator is provided as a rate or percent. Birth measures are percents, infant mortality measures are deaths per 1,000 births, and death measures are year 2000, age-adjusted mortality rates per 100,000 population. The notation, “nrf” indicates that numbers used to generate the rates or percents are small and would create unstable rates or percents for the county, if used. Small numbers are defined for birth and infant mortality indicators as fewer than 500 births and 3 events (births or infant deaths) or for death measures as fewer than 10 deaths.

Peer County Range — The low and the high values found in each stratum of peers is provided. The low number is the tenth percentile of rates or percents in the stratum; the high number represents the ninetieth percentile. Eighty percent of all county values within the strata lie within this range.

U.S. Rate — Age-adjusted (year 2000 standard), 1997 U.S. rates were taken from both Healthy People 2010: National Health Promotion and Disease Prevention Objectives (Conference Edition) and provided by NCHS (Personal communication, Richard Klein).

Healthy People 2010 Target — The national target rate or percent established for a national 2010 objective was found in Healthy People 2010: National Health Promotion and Disease Prevention Objectives (Conference Edition).

BIRTH MEASURES

NOTE: Data are from the National Center for Health Statistics, Vital Statistics Reporting System, 1988-1997.

Low Birth Weight — Percentage of all births less than 2,500 grams.

Very Low Birth Weight — Percentage of all births less than 1,500 grams.

Premature Births — Percentage of births with a reported gestation period of less than 37 weeks.

Teen Mothers — Percentage of all births to mothers less than 18 years of age.

Older Mothers — Percentage of all births to mothers 40 years of age or older.

Unmarried Mothers — Percentage of all births to mothers who report not being married.

No Care First Trimester — Percentage of births to mothers who reported receiving no prenatal care during the first trimester (12 weeks) of pregnancy, and includes those with no or unknown prenatal care.

INFANT MORTALITY

NOTE: All rates are deaths per 1,000 births.

Infant Mortality — Death of an individual less than one year old from any cause (any ICD-9 code).

Neonatal mortality — Infant deaths occurring before day 29.

Postneonatal mortality — Infant deaths occurring day 29 or later.

White/Black Infant Mortality — Race-specific infant mortality.

DEATH MEASURES

NOTE: In this section, the ICD-9 codes include causes of death corresponding to the definitions used in the Nation's health objectives outlined in Healthy People 2010: National Health Promotion and Disease Prevention Objectives (Conference Edition). All death rates (excluding infant mortality) are per 100,000 population.

Breast Cancer (Female) — ICD-9 code: 174.

Colon Cancer — ICD-9 codes: 153 and 154.

Coronary Heart Disease — ICD-9 codes: 402, 410-414, and 429.2.

Homicide — Murder, ICD-9 codes: E960-E969.

Lung Cancer — ICD-9 code: 162.

Motor Vehicle Injuries — ICD-9 codes: E810-E825.

Stroke — ICD-9 codes: 430-438

Suicide — Intentionally and voluntarily taking one’s own life, ICD-9 codes: E950-E959.

Unintentional Injury — Includes all injuries not related to motor vehicle accidents or intentional deaths (homicide or suicide) ICD-9 codes: E800-E807 and E826-E949.

RELATIVE HEALTH IMPORTANCE

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The Relative Health Importance Table conveys a straightforward way of prioritizing health issues for counties. Comparisons to the U.S. and to its peers allows a quick and easy method for assessing one’s county health relative to others.
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The Relative Health Importance Table creates four categories of relative concern by simply comparing one’s county to its peers and to the U.S. The table highlights favorable and unfavorable standing between one’s county, and other counties and the Nation, and points to indicators which may warrant more attention.

A county’s indicators in the upper left-hand box may be ripe for improvement. They are higher than the U.S. and half of the peer counties. The county compares unfavorably to both peers and the Nation for the indicators listed (i.e., a county rate higher than the median peer county rate is categorized as “unfavorable”).

Conversely, indicators in the lower right-hand box of the table compare favorably to both peers and the U.S. For these indicators the county has been doing relatively well. It is important to note that though a favorable relationship

currently exists, these indicators are likely to call for continued attention so that the current positive level of health status is sustained or additional progress made.

The other two boxes represent intermediate levels of health status. In one instance, the county does well relative to its peers while comparing unfavorably relative to the U.S. In the other, the county does poorly compared to its peers while comparing favorably to the U.S. In each case, one's county rate is lower than either its peers or the U.S., but not both.

Median values are used to designate indicators as favorable or unfavorable. Indicator values that are equal to the median are placed in the "favorable" column or row. Public health practitioners at the University of South Florida College of Public Health (Studnicki, J. et.al. (1997), Community health report card: Comprehensive Assessment for Tracking Community Health (CATCH), Best Practices and Benchmarking in Healthcare, Vol 2(5), 196-207) developed this methodology to allow counties to establish priorities among indicators, based on relative standing to peers and the U.S.

VULNERABLE POPULATIONS

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Vulnerable populations are estimates of individuals in various categories who tend to have poorer health status and more medical needs than the general population.
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NOTE: To obtain the estimates provided in this section, a national, local, or multivariately modeled prevalence is applied to the current local total or sub-population. While estimates using the same formula and source of population provide consistency across jurisdictions, as was desirable for this project, they may not supply individual counties with the only estimates of these populations. Other estimates may have been made by and be available from others, and in particular, the local or State health department.

No High School Diploma — The number of individuals age 25 and older who have not graduated from high school. Prevalence estimates of no high school diploma from the *1990 Census of Population and Housing* were applied to the 1997 county population estimates (ages>25), *STF3A, U.S. Bureau of the Census*, and obtained from the [Area Resource File](#), (Quality Resource Systems, Inc., Fairfax, VA, under contract with the Health Resources and Services Administration.)

Unemployed — The number of persons who had no employment, were available for work, and had made specific efforts to find employment were obtained. The number of unemployed compiled from the 1998 Current Population Survey (CPS) are provided by Local Area Unemployment Statistics, Bureau of Labor Statistics, for each county.

Severe Work Disability — Estimates were developed by Borawski, E.A. and Jia, H. (Case Western Reserve University, Department of Biostatistics) “State and County Estimates of Severe Work Disability (SWD) Among Adults, Aged 18-64, 1993-1996, Behavioral Risk Factor Surveillance System (BRFSS)” January, 1999. Prevalence estimates are applied to the 1997 county population estimates (age 18-64). Severe work disability is defined as the inability to work due to health problems — mental or physical. Due to small sample size, the confidence intervals for these data may be wide and should be consulted when making comparisons to Peer Counties because the variations observed may not be statistically valid. Estimates are based on national prevalence information and adjusted to reflect local demographic characteristics, therefore these estimates may not be accurate at the county level.

Major Depression — An estimate of the number of individuals, age 18 and older, experiencing a major depressive episode during the past year, was calculated using the following formula: (1996 race-specific prevalence) x (1997 county population age 18 and older). Race-specific U.S. prevalences are from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Statistics. *Substance Abuse and Mental Health Statistics Source Book*, 1998, (p. 126). Definition of a major depressive episode appears on page 459. This publication can be accessed electronically at www.samhsa.gov. Estimates are based on national prevalence information and adjusted to reflect local demographic characteristics, therefore these estimates may not be accurate at the county level.

Recent Drug Use — An estimate of the number of individuals, age 12 and older, using illicit drugs within the past month was calculated. The figure was calculated using the following formula: (1996-1998 average region-specific prevalence) x (1997 county population, age 12 and older). Illicit drug use includes use of one or more of the following: marijuana, cocaine (including crack), heroin, hallucinogens (including LSD and PCP), inhalants, or non-medical use of psychotherapeutics, Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Statistics). *Substance Abuse and Mental Health Statistics Source Book*, 1998, p. 70.

This publication can be accessed electronically at www.samhsa.gov. Estimates are based on national prevalence information and adjusted to reflect local demographic characteristics, therefore these estimates may not be accurate at the county level.

ENVIRONMENTAL HEALTH

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These measures provide a context for good health — clean air, water, land, and waste disposal — and are particularly important in assuring a healthy population.
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Infectious Diseases — Disease classifications are from the Centers for Disease Control and Prevention, “Case definitions for infectious conditions under public health surveillance,” MMWR 1997: 46(No. RR-10). This publication is available at www2.cdc.gov/mmwr/.

Data are from the Centers for Disease Control and Prevention, National Center for Infectious Diseases, 1989-1998. Depending upon county size, the number of cases for the most recent 3, 5, or 10 years is reported. The expected number is based on the rate for the strata of peer counties and the population estimate of the county.

Toxic Chemicals — Toxic Release Inventory (TRI) data, amount (in pounds) of total chemical releases was extracted using TRI Data Explorer software, 1996 data, U.S. Environmental Protection Agency, available at: www.epa.gov/ceisweb1/ceishome/ceisdata/triexplorer/triexplorer.html.

Air Quality Standards — The Clean Air Act directs the Environmental Protection Agency (EPA) to identify and set national ambient air quality standards for pollutants that cause adverse effects to public health and the environment. EPA has set standards for the following six pollutants: Carbon Monoxide (CO), Nitrogen Dioxide (NO₂), Ozone (O₃), Lead (Pb), Particulate Matter < 10 micrometers (PM-10) and Sulfur Dioxide (SO₂). A “No” indicates that the county reported a value that exceeds the air quality standard. A “Yes” indicates that a county did not exceed the standard, or does not currently monitor for that pollutant. An exceedance in any single year is not necessarily an indication that the county violates the national air quality standard. For more information on the National Ambient Air Quality Standards, and how to determine if a county is in violation of these standards, please visit www.epa.gov/oar/oaqps/greenbook/index.html. Summary 1998 data presented are available at www.epa.gov/airsdata/monsum.htm.

PREVENTIVE SERVICES USE

INFECTIOUS DISEASE CASES

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Infectious disease cases can be reduced with the systematic application of various public health measures — testing, counseling, treatment, and vaccination.
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Note: Disease classifications and case definitions are provided by the Centers for Disease Control and Prevention, in “Case definitions for infectious conditions under public health surveillance,” MMWR 1997: 46(No. RR-10). This publication is available at www2.cdc.gov/mmwr/.

Data are from the Centers for Disease Control and Prevention, National Center for Infectious Diseases and the National Center for HIV, STD, and TB, 1989-1998. Depending upon county size, the number of cases for the most recent 3, 5, or 10 years is reported. Data include all cases for which county of residence was specified. The expected number is based on the rate for the strata of peer counties and the county’s population estimate. (Expected number = rate among peers x county population).

ADULT PREVENTIVE SERVICES USE

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Our risk of developing certain cancers and suffering fatal consequences from respiratory illnesses can be reduced with the use of various preventive services. Early detection of cancer, through the use of screening tests, increases survival. In addition, preventing or reducing the severity of respiratory illness through the use of vaccinations reduces morbidity and death rates.
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NOTE: The Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted jointly by States and the Centers for Disease Control and Prevention, provides information about adult health practices related to a variety of health issues. State-level BRFSS survey data from 1997 or 1998 are presented. These data, including confidence intervals for survey estimates, are available on the BRFSS Web site at www.cdc.gov/nccdphp/brfss/. Local survey estimates may be available through your State BRFSS coordinator.

PAP SMEAR — The percentage of females, 18 years of age and older, who have had a Pap smear within the past 3 years. A Pap smear detects abnormal changes in cervical cells that may lead to cancer. Early detection of precancerous conditions and treatment can prevent cancer or death (1998).

Mammogram — The percentage of females, 50 years of age or older, who have had a mammogram within the past two years. A mammogram is a type of x-ray used to detect tumors or abnormal cells in the breast. Early detection and treatment of cancer can prevent death from breast cancer (1998).

Sigmoidoscopy — The percentage of adults, age 50 years and older, who have ever had a proctoscopic exam. This type of exam uses a flexible scope to detect polyps (non-cancerous tumors) and cancerous tumors in the colon and rectum. Finding and removing them early can prevent cancer or death from colon cancer (1997).

Pneumonia — The percentage of adults, age 65+, who have ever had a pneumonia vaccination. Pneumonia is a leading cause of death among older Americans; many pneumonia deaths can be prevented through increased use of this vaccine (1997).

Flu — The percentage of adults, age 65+, who have had a flu shot within the past year. Influenza is more likely to lead to serious complications, such as pneumonia, in older adults. Much of the illness and death caused by influenza can be prevented by yearly vaccination (1997).

RISK FACTORS FOR PREMATURE DEATH

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The characteristics presented here convey risks for heart disease and cancer, our Nation's leading killers. They include risk factors, personal behaviors, and lifestyle choices. Persons with risk factors are at increased risk of disease and its effects. Note: prevalences for your State are provided.
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NOTE: The Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted jointly by States and the Centers for Disease Control and Prevention, provides information on the prevalence of adult risk characteristics associated with the leading causes of death. State-level BRFSS survey data from 1997 or 1998 are presented. These data, including confidence intervals for survey estimates, are available on the BRFSS Web site at www.cdc.gov/nccdphp/brfss/. Local survey estimates may be available through your State BRFSS coordinator. These factors, reported for adults, are also important indicators of health in children and youth.

Sedentary — Sedentary lifestyle is the calculated percentage of adults at risk for health problems related to lack of exercise (regular and sustained physical activity) (1998).

Few fruits/vegetables — The percentage of adults reporting an average fruit and vegetable consumption of less than 5 times per day (1998).

Obesity — The calculated percentage of adults at risk for health problems related to being overweight, based on body mass index (BMI). A BMI of 27.8, for men, and 27.3, for women, or more is considered obese. To calculate BMI, multiply weight in pounds by 703 and divide the result by height (in inches) squared (1998).

High Blood Pressure — The percentage of adults who responded yes to the question, “Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?” (1997).

Smoker — The percentage of adults who responded “yes” to the question, “Do you smoke cigarettes now?” (1998).

Diabetes — The percentage of adults who responded “yes” to the question, “Have you ever been told by a doctor that you have diabetes?” (1998).

ACCESS TO CARE

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Access to care measures include health care resources available in a county and provide measures of medical care coverage or lack thereof.
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Uninsured Individuals — The estimated number of uninsured individuals in the State are from the 1998 Current Population Survey (CPS), <http://ftp.census.gov/hhes/hlthins/hlthin98.html>. The CPS is an ongoing survey of states. Information on survey methodology and confidence intervals are found at: www.bls.census.gov/cps/tp/tp63.htm and www.bls.census.gov/cps/cpsmain.htm.

Medicare Beneficiaries — Beneficiaries are the number of individuals enrolled in Medicare by State and county of residence, from the Health Care Financing Administration’s enrollees’ file, July 1, 1998. The data are available at: www.hcfa.gov/stats/enroll98.htm.

Medicaid Beneficiaries — The U.S. Health Care Financing Administration was not able to provide the number of beneficiaries by county. This number may be available for your county from the State Medicaid office.

Primary Care Physicians — This is the total number of active, non-federal physicians per 100,000 population, 1997. This figure includes those who practice in one of the four primary care specialties — general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology. Source: American Medical Association Physician Master File, 1997, [Area Resource File](#), (Quality Resource Systems, Inc., Fairfax, VA, under contract with the Health Resources and Services Administration.)

Dentists — This is the total number of active dentists per 100,000 population, 1995. Source: American Dental Association, State and County Demographic Reports, 1998, [Area Resource File](#), (Quality Resource Systems, Inc., Fairfax, VA, under contract with the Health Resources and Services Administration.)

Community Health Centers — These centers are a source of care for low-income and uninsured individuals and families, 1999. Their network includes migrant health centers, homeless health centers, and other community-based centers. Source: Bureau of Primary Health Care, Health Resources and Services Administration.

Health Professional Shortage Area — These are counties that have been designated as single-county, primary medical care, health professional shortage areas, as determined by the Secretary of Health and Human Services, current as of December 17, 1999. They have a shortage of health professionals, meeting the criteria from 42 Code of Federal Regulations, Chapter 1, part 5 (October 1, 1993, pp.34-48). Data are available at www.bphc.hrsa.gov/databases/hpsa/supplem.htm.

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For more information, please contact your State or local health department
or the project partners, or visit the
Community Health Status Indicators Project Web site:
www.communityhealth.hrsa.gov

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