2013 Community Health Needs Assessment

Clinton & Jackson Counties, Iowa

Sponsored by
Genesis Medical Center, DeWitt Campus
Jackson County Regional Health Center
# Table of Contents

**EXECUTIVE SUMMARY** .................................................................................................................. 4

- Introduction ........................................................................................................................................... 4
- Community Definition ............................................................................................................................. 4

**PROJECT OVERVIEW** ......................................................................................................................... 4
- Methods & Approach ................................................................................................................................. 4
- Information Gaps ...................................................................................................................................... 5
- Community Stakeholder Input .................................................................................................................. 5
- Existing Health Care Facilities & Resources .......................................................................................... 5

**IDENTIFIED HEALTH NEEDS** .......................................................................................................... 7
- Supportive Data ....................................................................................................................................... 7
- Prioritization of Health Needs ................................................................................................................... 9
- Public Dissemination ............................................................................................................................... 11

**DETAILED HEALTH INDICATORS** .................................................................................................... 13

- Demographics ........................................................................................................................................ 13
  - Total Population .................................................................................................................................. 13
  - Median Age .......................................................................................................................................... 14
  - Population Under Age 18 ...................................................................................................................... 15
  - Population Age 18-64 ........................................................................................................................... 20
  - Population Age 65+ ............................................................................................................................... 22
  - Hispanic Population ............................................................................................................................. 24
  - Foreign-Born Population ...................................................................................................................... 25
  - Population with Limited English Proficiency ..................................................................................... 26
  - Linguistically Isolated Households ....................................................................................................... 29
  - Population Geographic Mobility ........................................................................................................ 30
  - Urban and Rural Population ................................................................................................................. 31

- Social & Economic Factors ...................................................................................................................... 32
  - Adequate Social or Emotional Support ................................................................................................. 32
  - Children Eligible for Free/Reduced Price Lunch ............................................................................... 33
  - Children in Poverty ............................................................................................................................... 34
  - High School Graduation Rate ............................................................................................................... 35
  - Income Over $75,000 (Family) ............................................................................................................. 36
  - Population in Poverty (100% FPL) ..................................................................................................... 37
  - Population in Poverty (200% FPL) ..................................................................................................... 38
  - Population Receiving Medicaid .......................................................................................................... 39
  - Population with Associate’s Level Degree or Higher ......................................................................... 40
  - Population with No High School Diploma ......................................................................................... 41
  - Teen Births ........................................................................................................................................... 42
  - Uninsured Population (Adults) ............................................................................................................. 44
  - Uninsured Population (Children) ......................................................................................................... 45
  - Uninsured Population (Total) ............................................................................................................... 46

- Physical Environment ........................................................................................................................... 49
  - Air Quality (Ozone) ............................................................................................................................... 49
  - Air Quality (Particulate Matter 2.5) ..................................................................................................... 50
  - Fast Food Restaurant Access ............................................................................................................... 51
  - Grocery Store Access ............................................................................................................................ 52
  - Liquor Store Access .............................................................................................................................. 53
  - Low Income Population with Low Food Access .................................................................................. 54
  - Park Access .......................................................................................................................................... 55
  - Population with Low Food Access ...................................................................................................... 56
  - Recreation and Fitness Facility Access ................................................................................................. 57
  - SNAP-Authorized Food Store Access ................................................................................................. 58
  - Use of Public Transportation .............................................................................................................. 59
Executive Summary

INTRODUCTION

This Community Health Needs Assessment (CHNA) was conducted on behalf of Genesis Medical Center - DeWitt Campus and Jackson County Regional Health Center. This joint CHNA report yields information specific to the communities of each of these hospital facilities, allowing for independent determination of health priorities.

**Genesis Medical Center-DeWitt** (GMC-DeWitt) has served DeWitt and surrounding communities with compassionate, high quality care since 1952. Throughout the years, the hospital has successfully responded to a growing population and an evolving health care delivery system. GMC-DeWitt is a non-profit, charitable organization governed by the Genesis Health System board of trustees. As a member of Genesis Health System, GMC-DeWitt patients have access to extended services that a community hospital otherwise may not provide. The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which ensures that high standards of patient care are met.

**Jackson County Regional Health Center** (JCRHC), Jackson County’s only hospital, began as the result of a community vision to create a modern, full-service hospital to meet the needs of Jackson County residents and the surrounding area. That vision holds true today as JCRHC strives to meet the ever changing needs of the people it serves. Today Jackson County Regional Health Center is a 25 bed Joint Commission-accredited critical access hospital offering a wide range of inpatient, outpatient, emergency and community health services. Jackson County Regional Health Center has been affiliated with Genesis Health System since July 2010.

Community Definition

The community defined for this assessment includes Clinton and Jackson Counties in Iowa.

- Genesis Medical Center - DeWitt Campus serves the city of DeWitt and western Clinton County (from which it draws a majority of its patients). The city of Clinton at the east side of Clinton County is not part of GMC-DeWitt’s service area; however, because existing health-related data are only available at the county level, this CHNA includes the county in its entirety.

- As a county hospital, Jackson County Regional Health Center serves the population of Jackson County, Iowa.

A demographic description of the targeted population can be found in the first set of tables of the “Detailed Health Indicators” section of this report.

PROJECT OVERVIEW

Methods & Approach

To complete this CHNA, existing health-related data were collected via the online Community Commons Community Health Needs Assessment report tool at [http://www.communitycommons.org/maps-data](http://www.communitycommons.org/maps-data). This site allows for identification of 87 distinct health
and social indicators at the county level, along with comparisons to state and national data, and Healthy People 2020 Targets, where available. Once an indicator report was generated, relevant indicators were reviewed to determine how Clinton and Jackson Counties compared to available state/national data. See the “Detailed Health Indicators” section of this document.

**Information Gaps**

Because this CHNA relies on existing datasets, it is limited in scope to those indicators currently available through database collection. It does not include a primary research component, and many important issues are unaddressed (e.g., mental health, children’s health, etc.), or only addressed minimally (e.g., access to healthcare). Another limitation is that most measures included in this assessment represent data that are several years old.

**Community Stakeholder Input**

As part of this CHNA, Genesis Medical Center - DeWitt Campus and Jackson County Regional Health Center sought input from public health representatives and other community stakeholders with an interest in the health of the community through a series of discussion meetings.

Organizations represented at these community stakeholder meetings include:

- Teddy Crawford, Westwing Senior Living
- Michele Cullen, Clinton County Public Health Department
- Curt Coleman, GMC-DeWitt, Administration
- Gwen Deming, Community Partnership for Protecting Children
- Wanda Haack, GMC-DeWitt, Patient Health Services
- Jackson County Board of Health
- Carolyn Hassennmiller, GMC-DeWitt Social Services
- Jenny Kreiter, Early Childhood Iowa/DECAT Coordinator
- Kathryn McKnight, St. Ambrose University School of Health Sciences
- Kati McNeme, I-Smile, Visiting Nurse Services
- Paula River, GMC-DeWitt, Community Health Liaison
- Lynn Bopes, Jackson County Mental Health
- Cheryl Curl, JCRHC Chief Nursing Officer
- Curt Coleman, JCRHC, Administration
- Gwen Deming, Community Partnership for Protecting Children
- Pam DeMoss, Jackson County Board of Health
- Steve Flynn, Jackson County Supervisor
- Jennifer Hope, JCRHC Nursing Services

An important component to these meetings was a discussion of the primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups. This qualitative input was used to further inform the prioritization process described later in this summary.

**Existing Health Care Facilities & Resources**
The following represent known existing health care facilities and resources that are available to respond to the health needs of the community. These lists are not exhaustive and are subject to change, but these organizations represent potential partners in improving health in Clinton and Jackson Counties:

**Clinton County**
- American Red Cross
- Behavioral Health & Wellness Clinic
- Bridgeview Community Mental Health Center
- Clinton County Health Department
- Clinton County Visiting Nurse Association
- Clinton Urgent Care
- Community Action of Eastern Iowa
- Cornerstone Wellness Center
- DeWitt Family Health Clinic
- **Genesis Medical Center, DeWitt Campus**
- Girling Home Health Care
- Grand Mound Ambulance
- Guardian Family Care, Inc.
- The Healing Place
- Lutheran Services in Iowa
- Lost Nation Ambulance
- Maggie's House Assisted Living
- Mercy Medical Center
- Pathway Living Center, Inc.
- The Pregnancy Center
- Skyline Center
- Visiting Nurse Association
- West Wing Place Nursing Home
- Wheatland Manor & Lincolnway Villa Assisted Living
- Wyndcrest Nursing Home
- Women’s Health Services
- YWCA

**Jackson County**
- Gannon Center for Community Mental Health
- Hillcrest Family Services
- Home Instead Senior Care
- Hospice of Jackson County
- Jackson County Board of Health
- **Jackson County Regional Health Center**
- Lutheran Services
- Maquoketa Area Family YMCA
- Maquoketa Family Clinic
- Medical Associates of Maquoketa
- Physical & Sports Therapy Services
- Quad City Kidney
- Women’s Health Services
Identified Health Needs

Upon reviewing existing health indicator data (see the Detailed Health Indicators section), health needs for the community were identified to include all indicators for which either Clinton County or Jackson County (or the combined area) compares unfavorably to state data, national data, established Healthy People 2020 targets, or any combination thereof. These indicators were then grouped into the following health categories, which represent the identified health needs of the community:

- Access to Healthcare Services
- Alcohol, Tobacco & Other Drugs
- Cancer
- Chronic Disease
- Environmental Health
- Heart Disease & Stroke
- Injury
- Maternal/Infant Health & Family Planning (Clinton County only)
- Mental Health
- Nutrition, Physical Activity & Weight
- Oral Health
- Sexually Transmitted Diseases (Clinton County only)

These health issues, and dispositions of the related health indicators, are outlined in the following table.

<table>
<thead>
<tr>
<th>KEY</th>
<th>Clinton Co.</th>
<th>Jackson Co.</th>
<th>Combined Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>HP</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td></td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
</tbody>
</table>

**Key**:
- IA: Compares unfavorably to statewide data.
- US: Compares unfavorably to national data.
- HP: Fails to meet Healthy People 2020 Target (targets are only available for a few of these indicators)
- ?: Unknown — data are not available or are suppressed.

**Bolded** items are those which compare unfavorably at all levels.
<table>
<thead>
<tr>
<th>Category</th>
<th>Clinton Co.</th>
<th>Jackson Co.</th>
<th>Combined Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population With No High School Diploma</strong></td>
<td>IA</td>
<td>IA</td>
<td>IA</td>
</tr>
<tr>
<td><strong>ALCOHOL, TOBACCO &amp; OTHER DRUGS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Consumption</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Alcohol Expenditures</td>
<td>?</td>
<td>?</td>
<td>IA,US</td>
</tr>
<tr>
<td>Liquor Store Access</td>
<td>IA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Usage (Current Smokers)</td>
<td>IA,US</td>
<td>US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Tobacco Usage (Former or Current Smokers)</td>
<td>IA,US</td>
<td></td>
<td>IA,US</td>
</tr>
<tr>
<td>Tobacco Expenditures</td>
<td>?</td>
<td>?</td>
<td>IA,US</td>
</tr>
<tr>
<td>Tobacco Usage (Quit Attempt)</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td><strong>CANCER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Mortality</td>
<td>IA,US,HP</td>
<td>HP</td>
<td>IA,US,HP</td>
</tr>
<tr>
<td>Lung Cancer Incidence</td>
<td>US</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Incidence</td>
<td>IA,US</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon and Rectum Cancer Incidence</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
</tr>
<tr>
<td>Breast Cancer Screening (Mammogram)</td>
<td>IA</td>
<td>IA</td>
<td>IA</td>
</tr>
<tr>
<td>Cervical Screening (Pap Test)</td>
<td>IA,US</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHRONIC DISEASE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Prevalence</td>
<td>IA,US</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td>Diabetes Management (Hemoglobin A1c Test)</td>
<td>IA</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td>HIV Screenings</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Population With Any Disability</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td><strong>ENVIRONMENTAL HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air Quality (Particulate Matter 2.5)</td>
<td>IA</td>
<td>IA</td>
<td>IA</td>
</tr>
<tr>
<td><strong>HEART DISEASE &amp; STROKE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease Mortality</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
</tr>
<tr>
<td>Heart Disease Prevalence</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Stroke Mortality</td>
<td>HP</td>
<td>HP</td>
<td>HP</td>
</tr>
<tr>
<td>High Blood Pressure Management</td>
<td>IA,US</td>
<td>?</td>
<td>IA,US</td>
</tr>
<tr>
<td><strong>INJURY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MATERNAL/INFANT HEALTH &amp; FAMILY PLANNING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>IA,US,HP</td>
<td>?</td>
<td>IA,US,HP</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>IA,US</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td>Teen Births</td>
<td>IA,US</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate Social &amp; Emotional Support</td>
<td>IA, US</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td>Suicide</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
<td>IA,US,HP</td>
</tr>
<tr>
<td><strong>NUTRITION, PHYSICAL ACTIVITY &amp; WEIGHT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit/Vegetable Consumption</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Fruit/Vegetable Expenditures</td>
<td>?</td>
<td>?</td>
<td>US</td>
</tr>
<tr>
<td>Grocery Store Access</td>
<td>IA,US</td>
<td>IA,US</td>
<td>IA,US</td>
</tr>
<tr>
<td>Population With Low Food Access</td>
<td>IA,US</td>
<td></td>
<td>IA,US</td>
</tr>
<tr>
<td>Low Income Population With Low Food Access</td>
<td>IA,US</td>
<td></td>
<td>IA,US</td>
</tr>
<tr>
<td>SNAP-Authorized Food Store Access</td>
<td>IA</td>
<td></td>
<td>IA</td>
</tr>
<tr>
<td>WIC-Authorized Food Store Access</td>
<td>IA</td>
<td></td>
<td>IA</td>
</tr>
</tbody>
</table>
Supportive Data

Public Health CHNA & HIP. At least every five years, local boards of health lead a community-wide discussion with stakeholders and residents about their community’s health needs. After identifying needs in the community, the next step is to identify objectives and strategies to address those needs. This process — Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP) — is a fundamental element in statewide planning. CHNA & HIP has more than a 20-year history in Iowa and represents local action to promote and protect the health of Iowans.

Recent CHNA & HIP activities in both Clinton and Jackson Counties relate to several of the health needs identified in the quantitative data review described above. These include the following health issues:

Clinton County

- **Alcohol, Tobacco & Other Drugs** (Clinton County) — Identified prescription drug abuse as an issue and developed strategies to increase awareness and expand monitoring programs.
- **Maternal/Infant Health & Family Planning** (Clinton County) — Identified teen pregnancy as a problem and developed strategies to monitor and reduce repeat births among young mothers.
- **Nutrition, Physical Activity & Weight** (Clinton County) — Identified obesity as a problem and developed strategies to track students’ weight status and promote healthy lifestyles.

Jackson County

- **Alcohol, Tobacco & Other Drugs** (Jackson County) — Identified teen alcohol use as a problem and developed a performance measure to reduce alcohol consumption in high schoolers.
- **Environmental Health** (Jackson County) — Identified a lack of sewers/treatment systems in portions of the county as a problem and developed a performance measure to build a publicly owned sewer and treatment facility in Leisure Lake.
- **Mental Health** (Jackson County) — Identified teen suicide as a problem and developed a performance measure to increase awareness of suicide prevention strategies.
County Health Rankings. The County Health Rankings tool (http://www.countyhealthrankings.org) shows health indicators for nearly every county in the nation and ranks counties within each state. Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births. Based on data available for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives.

A review of the County Health Rankings data tool reveals:

- **Clinton County** ranks in the bottom quartile of Iowa counties for both overarching categories of Health Outcomes and Health Factors — in fact, Clinton County ranked last among Iowa counties for the subcategory of Health Behaviors.
  - Specific “Areas to Explore” include adults smoking, adult obesity, graduation rates, single-parent households.

- **Jackson County** ranks in the bottom half of Iowa counties for the subcategories of Morbidity Outcomes and Social & Economic Factors.
  - Specific “Areas to Explore” include adult smoking, adult obesity, excessive drinking, and education levels.

<table>
<thead>
<tr>
<th>COUNTY HEALTH RANKINGS (shows rank among 99 Iowa counties)</th>
<th>Clinton County</th>
<th>Jackson County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH OUTCOMES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality <em>(premature death)</em></td>
<td>86</td>
<td>48</td>
</tr>
<tr>
<td>Morbidity <em>(e.g., overall health status, low-weight births)</em></td>
<td>73</td>
<td>46</td>
</tr>
<tr>
<td><strong>HEALTH FACTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Behaviors <em>(e.g., smoking, drinking, weight)</em></td>
<td>99</td>
<td>20</td>
</tr>
<tr>
<td>Clinical Care <em>(e.g., uninsured rate, provider ratio, preventable hospitalizations)</em></td>
<td>49</td>
<td>34</td>
</tr>
<tr>
<td>Social &amp; Economic Factors <em>(e.g. education, income, crime)</em></td>
<td>90</td>
<td>56</td>
</tr>
<tr>
<td>Physical Environment <em>(e.g., air/water quality, access to health food)</em></td>
<td>76</td>
<td>45</td>
</tr>
</tbody>
</table>

Community Stakeholder (Qualitative) Input. From the community stakeholder meetings described previously, a number of issues emerged that support the quantitative findings detailed in the matrix above. Among these were:
Prioritization of Health Needs

To prioritize the CHNA findings internally, each hospital facility consulted a group of internal stakeholders to review the CHNA findings and prioritize the identified health needs to establish which would be best addressed by two facilities. The groups considered several criteria in deciding which of the health needs to focus on, including the following:

- **Magnitude** — *How many people are affected by a given health issue? How do we vary from state or national benchmarks? Healthy People 2020 targets?*
- **Seriousness & Impact** — *To what degree does this health issue lead to death or disability, or impair quality of life? To what degree does this health issue impact other quality of life and health-related issues?*
- **Feasibility** — *What is the likelihood of impacting this health issue, given available resources?*
- **Consequences of Inaction** — *What is the risk of exacerbating the problem by not addressing it at the earliest opportunity?*
- **Community Stakeholder Input** — *Was this issue identified as a need in the community stakeholder meetings? What vulnerable populations were identified?*

**Genesis Medical Center, DeWitt Campus**

The GMC-DeWitt internal stakeholder group met on September 16, 2013. After considering the findings against the aforementioned criteria, the group established the following prioritization of significant health issues in the community; it is these health needs which GMC-DeWitt will address in its Implementation Strategy:

1. Access to Health Care  
2. Mental Health  
3. Nutrition, Physical Activity & Weight  
4. Oral Health  
5. Screening & Immunizations

The remaining identified health needs were not deemed as significant, and a priority for these was not established for GMC-DeWitt.

- Alcohol/Tobacco/Drugs  
- Cancer  
- Chronic Disease  
- Environmental Health  
- Injury  
- STDs  
- Maternal/Infant Health & Family Planning  
- Heart Disease & Stroke
Jackson County Regional Health Center

The JCRHC internal stakeholder group met on September 19, 2013. After considering the findings against the aforementioned criteria, the group established the following prioritization of significant health issues in the community; it is these health needs which JCRHC will address in its Implementation Strategy:

1. Access to Healthcare
2. Mental Health
3. Nutrition, Physical Activity & Weight
4. Oral Health
5. Screening & Immunizations

The remaining identified health needs were not deemed as significant, and a priority for these was not established for JCRHC.

- Alcohol/Tobacco/Drugs
- Cancer
- Chronic Disease
- Environmental Health
- Injury
- STDs
- Maternal/Infant Health & Family Planning
- Heart Disease & Stroke

**PUBLIC DISSEMINATION**

This Community Health Needs Assessment will be made available to the public on the websites of the individual hospital facilities at [www.genesishealth.com/community](http://www.genesishealth.com/community) and [http://www.genesishealth.com/jacksoncounty/about-us/community-benefit/](http://www.genesishealth.com/jacksoncounty/about-us/community-benefit/)

These sites:

- Inform readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Each hospital facility will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. Each will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.
**Detailed Health Indicators**

The following section details health indicators for Clinton and Jackson Counties, Iowa, using existing local data generated from the Community Commons website at [http://www.communitycommons.org](http://www.communitycommons.org) [Report prepared by http://assessment.communitycommons.org on July 03, 2013© Community Commons & IP3.]. Community Commons is an initiative of Advancing the Movement, and powered by Institute for People, Place and Possibilities (IP3).

Details regarding these indicators and their collection — as described by Community Commons — are outlined in the Footnotes section of this document.

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**Full Health Indicators Report**

**DEMOGRAPHICS**

**Report Area:** Clinton County, Iowa; Jackson County, Iowa

<table>
<thead>
<tr>
<th>Demographics // Social &amp; Economic Factors // Physical Environment // Clinical Care // Health Behaviors // Health Outcomes</th>
</tr>
</thead>
</table>

Current population demographics and changes in demographic composition over time play a determining role in the types of health and social services needed by communities.
Total Population

This indicator reports total population and the population density. Population density is defined as the number of persons per square mile.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Land Area (Square Miles)</th>
<th>Population Density (Per Square Mile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>69,069</td>
<td>1,330.60</td>
<td>51.91</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>49,185</td>
<td>694.73</td>
<td>70.80</td>
</tr>
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<td>Iowa</td>
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<td>United States</td>
<td>3,032,266</td>
<td>55,842.35</td>
<td>54.30</td>
</tr>
<tr>
<td>United States</td>
<td>310,346,360</td>
<td>3,530,997.60</td>
<td>87.89</td>
</tr>
</tbody>
</table>


Population, Density (Persons per Sq Mile) by Tract, 2007-11

- Over 5,000
- 1,001 - 5,000
- 400.1 - 1,000
- 50.1 - 400.0
- Under 50.1
- No Data or Data Suppressed
### Total Population by Gender

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
<th>Percent Male</th>
<th>Percent Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>33,998</td>
<td>35,071</td>
<td>49.22%</td>
<td>50.78%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>24,182</td>
<td>25,003</td>
<td>49.17%</td>
<td>50.83%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>9,816</td>
<td>10,068</td>
<td>49.37%</td>
<td>50.63%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1,498,400</td>
<td>1,533,866</td>
<td>49.42%</td>
<td>50.58%</td>
</tr>
<tr>
<td>United States</td>
<td>150,740,224</td>
<td>155,863,552</td>
<td>49.16%</td>
<td>50.84%</td>
</tr>
</tbody>
</table>

### Total Population by Age Groups, Total

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Age 0-4</th>
<th>Age 5-17</th>
<th>Age 18-24</th>
<th>Age 25-34</th>
<th>Age 35-44</th>
<th>Age 45-54</th>
<th>Age 55-64</th>
<th>Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>4,071</td>
<td>12,273</td>
<td>5,403</td>
<td>7,322</td>
<td>8,365</td>
<td>10,890</td>
<td>8,869</td>
<td>11,876</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>3,003</td>
<td>8,699</td>
<td>4,041</td>
<td>5,418</td>
<td>5,904</td>
<td>7,681</td>
<td>6,239</td>
<td>8,200</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>1,068</td>
<td>3,574</td>
<td>1,362</td>
<td>1,904</td>
<td>2,461</td>
<td>3,209</td>
<td>2,630</td>
<td>3,676</td>
</tr>
<tr>
<td>Iowa</td>
<td>198,900</td>
<td>525,804</td>
<td>307,742</td>
<td>376,395</td>
<td>371,800</td>
<td>438,642</td>
<td>362,665</td>
<td>450,318</td>
</tr>
<tr>
<td>United States</td>
<td>20,170,376</td>
<td>53,877,372</td>
<td>30,507,896</td>
<td>40,668,824</td>
<td>41,683,228</td>
<td>44,579,668</td>
<td>35,507,588</td>
<td>39,608,816</td>
</tr>
</tbody>
</table>
### Total Population by Age Groups, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Age 0-4</th>
<th>Age 5-17</th>
<th>Age 18-24</th>
<th>Age 25-34</th>
<th>Age 35-44</th>
<th>Age 45-54</th>
<th>Age 55-64</th>
<th>Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>5.89%</td>
<td>17.77%</td>
<td>7.82%</td>
<td>10.60%</td>
<td>12.11%</td>
<td>15.77%</td>
<td>12.84%</td>
<td>17.19%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>6.11%</td>
<td>17.69%</td>
<td>8.22%</td>
<td>11.02%</td>
<td>12%</td>
<td>15.62%</td>
<td>12.68%</td>
<td>16.67%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>5.37%</td>
<td>17.97%</td>
<td>6.85%</td>
<td>9.58%</td>
<td>12.38%</td>
<td>16.14%</td>
<td>13.23%</td>
<td>18.49%</td>
</tr>
<tr>
<td>Iowa</td>
<td>6.56%</td>
<td>17.34%</td>
<td>10.15%</td>
<td>12.41%</td>
<td>12.26%</td>
<td>14.47%</td>
<td>11.96%</td>
<td>14.85%</td>
</tr>
<tr>
<td>United States</td>
<td>6.58%</td>
<td>17.57%</td>
<td>9.95%</td>
<td>13.26%</td>
<td>13.60%</td>
<td>14.54%</td>
<td>11.58%</td>
<td>12.92%</td>
</tr>
</tbody>
</table>

### Total Population by Race Alone, Total

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>65,622</td>
<td>1,424</td>
<td>290</td>
<td>116</td>
<td>76</td>
<td>360</td>
<td>1,181</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>46,227</td>
<td>1,350</td>
<td>288</td>
<td>112</td>
<td>0</td>
<td>337</td>
<td>871</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,395</td>
<td>74</td>
<td>2</td>
<td>4</td>
<td>76</td>
<td>23</td>
<td>310</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,782,349</td>
<td>85,714</td>
<td>52,881</td>
<td>9,958</td>
<td>1,112</td>
<td>47,376</td>
<td>52,876</td>
</tr>
<tr>
<td>United States</td>
<td>227,167,008</td>
<td>38,395,856</td>
<td>14,497,185</td>
<td>2,502,653</td>
<td>500,592</td>
<td>15,723,818</td>
<td>7,816,654</td>
</tr>
</tbody>
</table>
### Total Population by Race Alone, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>95.01%</td>
<td>2.06%</td>
<td>0.42%</td>
<td>0.17%</td>
<td>0.11%</td>
<td>0.52%</td>
<td>1.71%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>93.99%</td>
<td>2.74%</td>
<td>0.59%</td>
<td>0.23%</td>
<td>0%</td>
<td>0.69%</td>
<td>1.77%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>97.54%</td>
<td>0.37%</td>
<td>0.01%</td>
<td>0.02%</td>
<td>0.38%</td>
<td>0.12%</td>
<td>1.56%</td>
</tr>
<tr>
<td>Iowa</td>
<td>91.76%</td>
<td>2.83%</td>
<td>1.74%</td>
<td>0.33%</td>
<td>0.04%</td>
<td>1.56%</td>
<td>1.74%</td>
</tr>
<tr>
<td>United States</td>
<td>74.09%</td>
<td>12.52%</td>
<td>4.73%</td>
<td>0.82%</td>
<td>0.16%</td>
<td>5.13%</td>
<td>2.55%</td>
</tr>
</tbody>
</table>

### Hispanic Population by Race Alone, Total

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>725</td>
<td>87</td>
<td>0</td>
<td>51</td>
<td>0</td>
<td>350</td>
<td>227</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>605</td>
<td>84</td>
<td>0</td>
<td>51</td>
<td>0</td>
<td>337</td>
<td>154</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>120</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>73</td>
</tr>
<tr>
<td>Iowa</td>
<td>83,816</td>
<td>1,647</td>
<td>663</td>
<td>2,278</td>
<td>39</td>
<td>45,229</td>
<td>10,486</td>
</tr>
<tr>
<td>United States</td>
<td>30,436,958</td>
<td>946,191</td>
<td>164,151</td>
<td>453,559</td>
<td>31,350</td>
<td>15,069,277</td>
<td>2,114,077</td>
</tr>
</tbody>
</table>
### Hispanic Population by Race Alone, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>50.35%</td>
<td>6.04%</td>
<td>0%</td>
<td>3.54%</td>
<td>0%</td>
<td>24.31%</td>
<td>15.76%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49.15%</td>
<td>6.82%</td>
<td>0%</td>
<td>4.14%</td>
<td>0%</td>
<td>27.38%</td>
<td>12.51%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>57.42%</td>
<td>1.44%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>6.22%</td>
<td>34.93%</td>
</tr>
<tr>
<td>Iowa</td>
<td>58.14%</td>
<td>1.14%</td>
<td>0.46%</td>
<td>1.58%</td>
<td>0.03%</td>
<td>31.37%</td>
<td>7.27%</td>
</tr>
<tr>
<td>United States</td>
<td>61.84%</td>
<td>1.92%</td>
<td>0.33%</td>
<td>0.92%</td>
<td>0.06%</td>
<td>30.62%</td>
<td>4.30%</td>
</tr>
</tbody>
</table>

### Non-Hispanic Population by Race Alone, Total

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>64,897</td>
<td>1,337</td>
<td>290</td>
<td>65</td>
<td>76</td>
<td>10</td>
<td>954</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>45,622</td>
<td>1,266</td>
<td>288</td>
<td>61</td>
<td>0</td>
<td>0</td>
<td>717</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,275</td>
<td>71</td>
<td>2</td>
<td>4</td>
<td>76</td>
<td>10</td>
<td>237</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,698,533</td>
<td>84,067</td>
<td>52,218</td>
<td>7,680</td>
<td>1,073</td>
<td>2,147</td>
<td>42,390</td>
</tr>
<tr>
<td>United States</td>
<td>196,730,048</td>
<td>37,449,664</td>
<td>14,333,034</td>
<td>2,049,094</td>
<td>469,242</td>
<td>654,541</td>
<td>5,702,577</td>
</tr>
</tbody>
</table>
### Non-Hispanic Population by Race Alone, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Native American / Alaska Native</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>95.96%</td>
<td>1.98%</td>
<td>0.43%</td>
<td>0.10%</td>
<td>0.11%</td>
<td>0.01%</td>
<td>1.41%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>95.14%</td>
<td>2.64%</td>
<td>0.60%</td>
<td>0.13%</td>
<td>0%</td>
<td>0%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>97.97%</td>
<td>0.36%</td>
<td>0.01%</td>
<td>0.02%</td>
<td>0.39%</td>
<td>0.05%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Iowa</td>
<td>93.44%</td>
<td>2.91%</td>
<td>1.81%</td>
<td>0.27%</td>
<td>0.04%</td>
<td>0.07%</td>
<td>1.47%</td>
</tr>
<tr>
<td>United States</td>
<td>76.43%</td>
<td>14.55%</td>
<td>5.57%</td>
<td>0.80%</td>
<td>0.18%</td>
<td>0.25%</td>
<td>2.22%</td>
</tr>
</tbody>
</table>

![Pie chart showing the distribution of non-Hispanic population by race alone across different report areas](chart.png)
Median Age

This indicator reports population median age based on the 5-year American Community Survey estimate.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>69,069</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>49,185</td>
<td>41.10</td>
</tr>
<tr>
<td>Iowa</td>
<td>19,884</td>
<td>43.10</td>
</tr>
<tr>
<td>United States</td>
<td>3,032,266</td>
<td>38</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>38</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>37</td>
</tr>
</tbody>
</table>

Population Under Age 18

This indicator reports the percentage of population under age 18 in the designated geographic area. This indicator is relevant because it is important to understand the percentage of youth in the community, as this population has unique health needs which should be considered separately from other age groups.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population Age 0-17</th>
<th>Percent Population Age 0-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,069</td>
<td>16,344</td>
<td>23.66%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,185</td>
<td>11,702</td>
<td>23.79%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,884</td>
<td>4,642</td>
<td>23.35%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>724,704</td>
<td>23.90%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>74,047,760</td>
<td>24.15%</td>
</tr>
</tbody>
</table>

Population Age 18-64

This indicator reports the percentage of population age 18-64 in the designated geographic area. This indicator is relevant because it is important to understand the percentage of adults in the community, as this population has unique health needs which should be considered separately from other age groups.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population Age 18-64</th>
<th>Percent Population Age 0-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,069</td>
<td>40,849</td>
<td>59.14%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,185</td>
<td>29,283</td>
<td>59.54%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,884</td>
<td>11,566</td>
<td>58.17%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>1,857,244</td>
<td>61.25%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>192,947,216</td>
<td>62.93%</td>
</tr>
</tbody>
</table>


Population Age 18-64, Percent by Tract, 2007-11

- Over 66.0%
- 62.1 - 66.0%
- 59.1 - 62.0%
- Under 59.1%
- No Data or Data Suppressed
Population Age 65+

This indicator reports the percentage of population age 65 and older in the designated geographic area. This indicator is relevant because it is important to understand the percentage of adults in the community, as this population has unique health needs which should be considered separately from other age groups.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population Age 65</th>
<th>Percent Population Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,069</td>
<td>11,876</td>
<td>17.19%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,185</td>
<td>8,200</td>
<td>16.67%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,884</td>
<td>3,676</td>
<td>18.49%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>450,318</td>
<td>14.85%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>39,608,816</td>
<td>12.92%</td>
</tr>
</tbody>
</table>


Population Age 65 , Percent by Tract, 2007-11

- Over 17.0%
- 13.1 - 17.0%
- 9.1 - 13.0%
- Under 9.1%
- No Data or Data Suppressed
**Hispanic Population**

This indicator reports the percentage of population that is of Hispanic, Latino, or Spanish origin. Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Hispanic or Latino Population</th>
<th>Percent Population Hispanic or Latino</th>
<th>Non-Hispanic Population</th>
<th>Percent Population Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,069</td>
<td>1,440</td>
<td>2.08%</td>
<td>67,629</td>
<td>97.92%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,185</td>
<td>1,231</td>
<td>2.50%</td>
<td>47,954</td>
<td>97.50%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,884</td>
<td>209</td>
<td>1.05%</td>
<td>19,675</td>
<td>98.95%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>144,158</td>
<td>4.75%</td>
<td>2,888,108</td>
<td>95.25%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>49,215,564</td>
<td>16.05%</td>
<td>257,388,208</td>
<td>83.95%</td>
</tr>
</tbody>
</table>


**Population, Hispanic or Latino, Percent by Tract, 2007-11**

- Over 20.0%
- 7.1 - 20.0%
- 3.1 - 7.0%
- Under 3.1%
- No Hispanic Population Reported
- No Data or Data Suppressed
Foreign-Born Population

This indicator reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national at birth. This includes any non-citizens, as well as persons born outside of the U.S. who have become naturalized citizens. The native U.S. population includes any person born in the United States, Puerto Rico, a U.S. Island Area (such as Guam), or abroad of American (U.S. citizen) parent or parents.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,069</td>
<td>477</td>
<td>355</td>
<td>832</td>
<td>1.20%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,185</td>
<td>415</td>
<td>296</td>
<td>711</td>
<td>1.45%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,884</td>
<td>62</td>
<td>59</td>
<td>121</td>
<td>0.61%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,032,266</td>
<td>47,402</td>
<td>81,066</td>
<td>128,468</td>
<td>4.24%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>17,150,684</td>
<td>22,118,154</td>
<td>39,268,838</td>
<td>12.81%</td>
</tr>
</tbody>
</table>

Data Source: [U.S. Census Bureau, 2007-2011 American Community Survey 5-Year Estimates](https://www.census.gov/). Source geography: County.

Foreign-Born Population (Non-Citizen or Naturalized), Percent by County, 2007-11

- **Over 8.0%**
- **4.1 - 8.0%**
- **2.1 - 4.0%**
- **1.1 - 2.0%**
- **Under 1.1%**
Population with Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well." This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>64,998</td>
<td>64,998</td>
<td>581</td>
<td>0.89%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>46,182</td>
<td>46,182</td>
<td>408</td>
<td>0.88%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>18,816</td>
<td>18,816</td>
<td>173</td>
<td>0.92%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,833,366</td>
<td>2,833,366</td>
<td>82,658</td>
<td>2.92%</td>
</tr>
<tr>
<td>United States</td>
<td>286,433,408</td>
<td>286,433,396</td>
<td>24,950,792</td>
<td>8.71%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population with Limited English Proficiency, Percent by Tract, 2007-11
### Population with Limited English Proficiency by Ethnicity Alone

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Hispanic / Latino</th>
<th>Total Not Hispanic / Latino</th>
<th>Percent Hispanic / Latino</th>
<th>Percent Not Hispanic / Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>272</td>
<td>309</td>
<td>21.69%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>265</td>
<td>143</td>
<td>25.07%</td>
<td>0.32%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>7</td>
<td>166</td>
<td>3.55%</td>
<td>0.89%</td>
</tr>
<tr>
<td>Iowa</td>
<td>43,738</td>
<td>38,920</td>
<td>35.17%</td>
<td>1.44%</td>
</tr>
<tr>
<td>United States</td>
<td>15,893,898</td>
<td>9,056,894</td>
<td>36%</td>
<td>3.74%</td>
</tr>
</tbody>
</table>

![Bar chart showing the percentage of Hispanic/Latino and non-Hispanic/Latino populations in different regions.

- Report Area: 21.69% Hispanic, 0.48% non-Hispanic
- Clinton County, IA: 25.07% Hispanic, 0.32% non-Hispanic
- Jackson County, IA: 3.55% Hispanic, 0.89% non-Hispanic
- Iowa: 35.17% Hispanic, 1.44% non-Hispanic
- United States: 36% Hispanic, 3.74% non-Hispanic]
<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black or African American</th>
<th>Native American / Alaska Native</th>
<th>Asian</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>0.48%</td>
<td>3.28%</td>
<td>37.84%</td>
<td>19.27%</td>
<td>50.82%</td>
<td>36.89%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>0.36%</td>
<td>3.44%</td>
<td>39.25%</td>
<td>19.34%</td>
<td>no data</td>
<td>39.86%</td>
<td>0%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>0.77%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>50.82%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.56%</td>
<td>3.72%</td>
<td>7.78%</td>
<td>36.19%</td>
<td>23.27%</td>
<td>43.58%</td>
<td>5.19%</td>
</tr>
<tr>
<td>United States</td>
<td>5.93%</td>
<td>2.77%</td>
<td>8.47%</td>
<td>35.49%</td>
<td>13.20%</td>
<td>40.29%</td>
<td>7.33%</td>
</tr>
</tbody>
</table>

![Bar chart showing population with limited English proficiency by race for Report Area, Clinton County, IA, Jackson County, IA, Iowa, and United States. The chart uses bars of different colors to represent different races and percentages, with labels for each category.
Linguistically Isolated Households

This indicator reports the percentage of the population aged 5 and older who live in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speak a non-English language and speak English "very well."

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 5</th>
<th>Linguistically Isolated Population</th>
<th>Percent Linguistically Isolated Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>64,998</td>
<td>407</td>
<td>0.63%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>46,182</td>
<td>292</td>
<td>0.63%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>18,816</td>
<td>115</td>
<td>0.61%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,833,366</td>
<td>50,769</td>
<td>1.79%</td>
</tr>
<tr>
<td>United States</td>
<td>286,433,408</td>
<td>14,321,466</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Population in Linguistically Isolated Households, Percent by Tract, 2007-11

- Over 6.0%
- 2.1 - 6.0%
- 0.1 - 2.0%
- 0.0%
- No Data or Data Suppressed
Population Geographic Mobility

This indicator reports information about population in-migration by assessing changes in residence within a one year period. Persons who moved to a new household from outside of their current county of residence, from outside their state of residence, or from abroad are considered part of the in-migrated population. Persons who moved to a new household from a different household within their current county of residence are not included.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population In-Migration</th>
<th>Percent Population In-Migration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,227</td>
<td>2,850</td>
<td>4.18%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>48,556</td>
<td>2,246</td>
<td>4.63%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,671</td>
<td>604</td>
<td>3.07%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,993,606</td>
<td>199,349</td>
<td>6.66%</td>
</tr>
<tr>
<td>United States</td>
<td>302,754,912</td>
<td>18,633,068</td>
<td>6.15%</td>
</tr>
</tbody>
</table>


Moved from Outside of the County, State, or Country, Percent by Tract, 2007-11

- Over 10.0%
- 6.1 - 10.0%
- 4.1 - 6.0%
- 2.1 - 4.0%
- Under 2.1%
- No Data or Data Suppressed
Urban and Rural Population

This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Urban Population</th>
<th>Rural Population</th>
<th>Percent Urban</th>
<th>Percent Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>42,559</td>
<td>26,405</td>
<td>61.71%</td>
<td>38.29%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>33,284</td>
<td>15,832</td>
<td>67.77%</td>
<td>32.23%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>9,275</td>
<td>10,573</td>
<td>46.73%</td>
<td>53.27%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>1,950,256</td>
<td>1,096,099</td>
<td>64.02%</td>
<td>35.98%</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>252,746,527</td>
<td>59,724,800</td>
<td>80.89%</td>
<td>19.11%</td>
</tr>
</tbody>
</table>


Urban Population, Percent by Tract, 2010

- 100% Urban Population
- 90.1 - 99.9%
- 50.1 - 90.0%
- Under 50.1%
- No Urban Population
- No Data or Data Suppressed
SOCIAL & ECONOMIC FACTORS

Economic and social insecurity often are associated with poor health. Poverty, unemployment, and lack of educational achievement affect access to care and a community’s ability to engage in healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.

Adequate Social or Emotional Support

This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all of most of the time. This indicator is relevant because social and emotional support is critical for navigating the challenges of daily life as well as for good mental health. Social and emotional support is also linked to educational achievement and economic stability.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>9,543</td>
<td>18.11%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>8,049</td>
<td>21.50%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>1,494</td>
<td>9.80%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,292,276</td>
<td>362,180</td>
<td>15.80%</td>
</tr>
<tr>
<td>United States</td>
<td>229,932,154</td>
<td>48,120,965</td>
<td>20.93%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Population Without Adequate Social or Emotional Support, Adults (Age 18), Percent by County, 2005-11

- Over 23.0%
- 19.1 - 23.0%
- 15.1 - 19.0%
- Under 15.1%
- No Data or Data Suppressed
Children Eligible for Free/Reduced Price Lunch

This indicator reports the percentage of public school students eligible for free or reduced price lunches. This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs. Additionally, when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Student Enrollment</th>
<th>Number Free/Reduced Price Lunch Eligible</th>
<th>Percent Free/Reduced Price Lunch Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>11,130</td>
<td>4,674</td>
<td>41.99%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>8,028</td>
<td>3,448</td>
<td>42.95%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>3,102</td>
<td>1,226</td>
<td>39.52%</td>
</tr>
<tr>
<td>Iowa</td>
<td>485,099</td>
<td>188,727</td>
<td>38.90%</td>
</tr>
<tr>
<td>United States</td>
<td>49,692,766</td>
<td>24,021,069</td>
<td>48.34%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Students Eligible for Free or Reduced-Price Lunch, Percent by School, 2009-10

- Over 80.0%
- 60.1 - 80.0%
- 40.1 - 60.0%
- 20.1 - 40.0%
- Under 20.1%
- Not Reported
Children in Poverty

This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,014</td>
<td>16,108</td>
<td>2,705</td>
<td>16.79%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>48,393</td>
<td>11,491</td>
<td>2,191</td>
<td>19.07%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,621</td>
<td>4,617</td>
<td>514</td>
<td>11.13%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,932,765</td>
<td>710,629</td>
<td>109,269</td>
<td>15.38%</td>
</tr>
<tr>
<td>United States</td>
<td>298,788,000</td>
<td>72,906,664</td>
<td>14,550,805</td>
<td>19.96%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, 2007-11
High School Graduation Rate

This indicator reports the average freshman graduate rate, which measures the percentage of students receiving their high school diploma within four years. This indicator is relevant because low levels of education are often linked to poverty and poor health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Freshman Base Enrollment</th>
<th>Estimated Number of Diplomas Issued</th>
<th>On-Time Graduation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>1,016</td>
<td>888</td>
<td>87.40</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>686</td>
<td>582</td>
<td>84.80</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>330</td>
<td>306</td>
<td>92.70</td>
</tr>
<tr>
<td>Iowa</td>
<td>39,571</td>
<td>33,926</td>
<td>85.70</td>
</tr>
<tr>
<td>United States</td>
<td>4,024,345</td>
<td>3,039,015</td>
<td>75.50</td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td>&gt;82.4</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target. No breakout data available.


Average Freshman Graduation Rate, Percent by School District, 2008-09

- Over 94.0%
- 87.1 - 94.0%
- 80.1 - 87.0%
- 72.1 - 80%
- Under 72.1%
Income Over $75,000 (Family)

This indicator reports the percentage of families with total annual income of $75,000 or greater. Total income includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Families</th>
<th>Families with Income Over $75,000</th>
<th>Percent Families with Income Over $75,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>18,501</td>
<td>6,931</td>
<td><strong>37.46%</strong></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>12,813</td>
<td>5,049</td>
<td><strong>39.41%</strong></td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>5,688</td>
<td>1,882</td>
<td><strong>33.09%</strong></td>
</tr>
<tr>
<td>Iowa</td>
<td>793,956</td>
<td>317,771</td>
<td>40.02%</td>
</tr>
<tr>
<td>United States</td>
<td>76,507,232</td>
<td>32,303,920</td>
<td>42.22%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Family Households with Income Over $75,000, Percent by Tract, 2007-11

- Over 55.0%
- 37.1 - 55.0%
- 23.1 - 37.0%
- Under 23.1%
- No Data or Data Suppressed
Population in Poverty (100% FPL)

Poverty is considered a *key driver* of health status.

This indicator reports the percentage of the population living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population in Poverty</th>
<th>Percent Population in Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,014</td>
<td>7,554</td>
<td>11.11%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>48,393</td>
<td>5,713</td>
<td>11.81%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,621</td>
<td>1,841</td>
<td>9.38%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,932,765</td>
<td>347,536</td>
<td>11.85%</td>
</tr>
<tr>
<td>United States</td>
<td>298,788,000</td>
<td>42,739,924</td>
<td>14.30%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


**Population Below the Poverty Level, Percent by Tract, 2007-11**

- Over 21.0%
- 12.1 - 21.0%
- 6.1 - 12.0%
- Under 6.1%
- No Data or Data Suppressed
Population in Poverty (200% FPL)

This indicator reports the percentage of the population living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population with Income at or Below 200% FPL</th>
<th>Percent Population with Income at or Below 200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,014</td>
<td>20,803</td>
<td>30.59%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>48,393</td>
<td>14,973</td>
<td>30.94%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,621</td>
<td>5,830</td>
<td>29.71%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,932,765</td>
<td>872,918</td>
<td>29.76%</td>
</tr>
<tr>
<td>United States</td>
<td>298,788,000</td>
<td>97,686,536</td>
<td>32.69%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Population Below 200% Poverty Level, Percent by Tract, 2007-11

- Over 50.0%
- 35.1 - 50.0%
- 20.1 - 35.0%
- Under 20.1%
- No Data or Data Suppressed
Population Receiving Medicaid

This indicator reports the percentage of the population that is enrolled in Medicaid. This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Population (for Whom Insurance Status is Determined)</th>
<th>Population Receiving Medicaid</th>
<th>Percent Population Receiving Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,922</td>
<td>11,486</td>
<td>16.67%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,094</td>
<td>8,063</td>
<td>18.16%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,828</td>
<td>3,423</td>
<td>19.19%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,048,461</td>
<td>456,353</td>
<td>14.97%</td>
</tr>
<tr>
<td>United States</td>
<td>309,231,232</td>
<td>51,335,184</td>
<td>19.91%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Data Source: U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates. Source geography: PUMA.

Insured, Medicaid / Means-Tested Coverage, Percent by PUMA, 2009-11

- Over 27.0%
- 20.1 - 27.0%
- 13.1 - 20.0%
- Under 13.1%
Population with Associate's Level Degree or Higher

This indicator reports the percentage of the population aged 25 and older obtaining an Associate's level degree or higher. This indicator is relevant because educational attainment is a key driver of population health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 25</th>
<th>Population Age 25 with Associate's Degree or Higher</th>
<th>Percent Population Age 25 with Associate's Degree or Higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>47,322</td>
<td>12,314</td>
<td>26.02%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>33,442</td>
<td>9,270</td>
<td>27.72%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>13,880</td>
<td>3,044</td>
<td>21.93%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1,999,820</td>
<td>697,096</td>
<td>34.86%</td>
</tr>
<tr>
<td>United States</td>
<td>202,048,128</td>
<td>72,317,672</td>
<td>35.79%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Population with No High School Diploma

This indicator reports the percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher. This indicator is relevant as educational attainment is a key driver of population health.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>47,322</td>
<td>5,185</td>
<td>10.96%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>33,442</td>
<td>3,449</td>
<td>10.31%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>13,880</td>
<td>1,736</td>
<td>12.51%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1,999,820</td>
<td>193,787</td>
<td>9.69%</td>
</tr>
<tr>
<td>United States</td>
<td>202,048,128</td>
<td>29,518,934</td>
<td>14.61%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Teen Births

This indicator reports the rate of total births to women under the age of 15 - 19 per 1,000 female population age 15 - 19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Female Population Age 15 - 19</th>
<th>Births to Mothers Age 15 - 19</th>
<th>Teen Birth Rate (Per 1,000 Births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>16,467</td>
<td>632</td>
<td>38.38</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>11,651</td>
<td>501</td>
<td>43</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>4,816</td>
<td>131</td>
<td>27.20</td>
</tr>
<tr>
<td>Iowa</td>
<td>733,129</td>
<td>23,900</td>
<td>32.60</td>
</tr>
<tr>
<td>United States</td>
<td>72,071,117</td>
<td>2,969,330</td>
<td>41.20</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Teen Births, Females (Age 15-19), Rate (Per 100,000 Pop.) by County, 2003-09

- Over 67.0
- 46.1 - 67.0
- 31.1 - 46.0
- Under 31.1
- No Data or Data Suppressed
### Teenage Girls by Race / Ethnicity, Birth Rate (Per 1,000 Births)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White (Non-Hispanic)</th>
<th>Black (Non-Hispanic)</th>
<th>Asian</th>
<th>American Indian / Alaskan Native</th>
<th>Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>36.70</td>
<td>80.30</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>41</td>
<td>80.30</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>26.70</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>27.10</td>
<td>84.10</td>
<td>24</td>
<td>79</td>
<td>102.30</td>
</tr>
<tr>
<td>United States</td>
<td>26.30</td>
<td>62.40</td>
<td>16.70</td>
<td>57.50</td>
<td>79.70</td>
</tr>
</tbody>
</table>

The chart provides a visual representation of the birth rate per 1,000 births for different racial and ethnic groups across different report areas and the United States.
Uninsured Population (Adults)

The lack of health insurance is considered a *key driver* of health status.

This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>56,304</td>
<td>5,620</td>
<td>9.98%</td>
<td>50,684</td>
<td>90.02%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>40,308</td>
<td>3,757</td>
<td>9.30%</td>
<td>36,551</td>
<td>90.70%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,996</td>
<td>1,863</td>
<td>11.60%</td>
<td>14,133</td>
<td>88.40%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,516,872</td>
<td>270,219</td>
<td>10.74%</td>
<td>2,246,653</td>
<td>89.26%</td>
</tr>
<tr>
<td>United States</td>
<td>262,403,381</td>
<td>46,556,803</td>
<td>17.74%</td>
<td>215,846,576</td>
<td>82.26%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average. No breakout data available.*

*Data Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE), 2010. Source geography: County.*

Uninsured Population, Adults Age 18-64, Percent by County, 2010

- Over 30.0%
- 25.1 - 30.0%
- 20.1 - 25.0%
- 15.1 - 20.0%
- Under 15.1%
Uninsured Population (Children)

The lack of health insurance is considered a key driver of health status.

This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>16,816</td>
<td>655</td>
<td>3.90%</td>
<td>16,161</td>
<td>96.10%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>12,023</td>
<td>442</td>
<td>3.70%</td>
<td>11,581</td>
<td>96.30%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>4,793</td>
<td>213</td>
<td>4.40%</td>
<td>4,580</td>
<td>95.60%</td>
</tr>
<tr>
<td>Iowa</td>
<td>748,462</td>
<td>30,343</td>
<td>4.05%</td>
<td>718,120</td>
<td>95.95%</td>
</tr>
<tr>
<td>United States</td>
<td>76,968,561</td>
<td>6,505,941</td>
<td>8.45%</td>
<td>70,462,624</td>
<td>91.55%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE), 2010. Source geography: County.

Uninsured Population, Children Age 0-17, Percent by County, 2010

- Over 14.0%
- 11.1 - 14.0%
- 8.1 - 11.0%
- 5.1 - 8.0%
- Under 5.1%
Uninsured Population (Total)

The lack of health insurance is considered a key driver of health status.

This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (For Whom Insurance Status is Determined)</th>
<th>Number Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,922</td>
<td>6,083</td>
<td>8.83%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,094</td>
<td>4,317</td>
<td>8.86%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,828</td>
<td>1,766</td>
<td>9.01%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,048,461</td>
<td>268,050</td>
<td>8.79%</td>
</tr>
<tr>
<td>United States</td>
<td>309,231,232</td>
<td>46,282,216</td>
<td>15.22%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Data Source: U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates. Source geography: PUMA.

Uninsured Population, Percent by PUMA, 2009-11

- Over 18.0%
- 14.1 - 18.0%
- 10.1 - 14.0%
- Under 10.1%
## Uninsured Population by Gender

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Male</th>
<th>Total Female</th>
<th>Percent Male</th>
<th>Percent Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>3,216</td>
<td>2,867</td>
<td>9.54%</td>
<td>8.29%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>2,292</td>
<td>2,025</td>
<td>9.54%</td>
<td>8.20%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>924</td>
<td>842</td>
<td>9.53%</td>
<td>8.50%</td>
</tr>
<tr>
<td>Iowa</td>
<td>147,778</td>
<td>120,272</td>
<td>9.95%</td>
<td>7.92%</td>
</tr>
<tr>
<td>United States</td>
<td>24,979,664</td>
<td>21,302,552</td>
<td>16.84%</td>
<td>13.68%</td>
</tr>
</tbody>
</table>

![Bar chart comparing uninsured population by gender for Report Area, Iowa, and United States](chart.png)
### Uninsured Population by Race Alone, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black or African American</th>
<th>Native American / Alaska Native</th>
<th>Asian</th>
<th>Native Hawaiian / Pacific Islander</th>
<th>Some Other Race</th>
<th>Multiple Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>7.84%</td>
<td>17.89%</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>20.21%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>7.88%</td>
<td>17.89%</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>18.22%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>7.74%</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>22.04%</td>
</tr>
<tr>
<td>Iowa</td>
<td>8.14%</td>
<td>15.37%</td>
<td>22.62%</td>
<td>11.10%</td>
<td>no data</td>
<td>32.95%</td>
<td>12.59%</td>
</tr>
<tr>
<td>United States</td>
<td>13.41%</td>
<td>17.91%</td>
<td>28.52%</td>
<td>15.31%</td>
<td>17.64%</td>
<td>34.17%</td>
<td>14.56%</td>
</tr>
</tbody>
</table>

**Diagram:**

- **White:** Blue
- **Black or African American:** Red
- **Native American / Alaska Native:** Yellow
- **Asian:** Green
- **Native Hawaiian / Pacific Islander:** Red
- **Some Other Race:** Green
- **Multiple Race:** Blue

**Legend:**

- Report Area
- Iowa
- United States
PHYSICAL ENVIRONMENT

A community’s health also is affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health.

Air Quality (Ozone)

This indicator reports the percentage of days per year with Ozone (O3) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb). Figures are calculated using data collected by monitoring stations and modeled to include census tracts where no monitoring stations exist. This indicator is relevant because poor air quality contributes to respiratory issues and overall poor health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Daily Ambient Ozone Concentration</th>
<th>Number of Days Exceeding Emissions Standards</th>
<th>Percentage of Days Exceeding Standards, Crude Average</th>
<th>Percentage of Days Exceeding Standards, Pop. Adjusted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>36.87</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>36.89</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>36.82</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>36.82</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>38.98</td>
<td>1.59</td>
<td>0.44%</td>
<td>0.47%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Days Above NAAQ Standards for Ozone (O3), Percent by Tract, 2008

- Over 6.0%
- 1.1 - 6.0%
- 0.51 - 1.0%
- Under 0.51%
- No Days Above NAAQS Standards
- No Data or Data Suppressed
Air Quality (Particulate Matter 2.5)

This indicator reports the percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year, calculated using data collected by monitoring stations and modeled to include counties where no monitoring stations occur. This indicator is relevant because poor air quality contributes to respiratory issues and overall poor health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Daily Ambient Particulate Matter 2.5</th>
<th>Number of Days Exceeding Emissions Standards</th>
<th>Percentage of Days Exceeding Standards, Crude Average</th>
<th>Percentage of Days Exceeding Standards, Pop. Adjusted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>10.17</td>
<td>1.39</td>
<td>0.38%</td>
<td>0.38%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>10.43</td>
<td>1.58</td>
<td>0.43%</td>
<td>0.42%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>9.66</td>
<td>1</td>
<td>0.27%</td>
<td>0.27%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>8.90</td>
<td>0.30</td>
<td>0.08%</td>
<td>0.09%</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>10.65</td>
<td>4.17</td>
<td>1.14%</td>
<td>1.19%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


---

Days Above NAAQ Standards for Particulate Matter (PM 2.5), Percent by Tract, 2008

- Over 6.0%
- 1.1 - 6.0%
- 0.51 - 1.0%
- Under 0.51%
- No Days Above NAAQS Standards
- No Data or Data Suppressed
Fast Food Restaurant Access

This indicator reports the number of fast food restaurants per 100,000 population. Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>34</td>
<td>49.30</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>27</td>
<td>54.97</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>7</td>
<td>35.27</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>1,888</td>
<td>61.98</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>216,243</td>
<td>70.04</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

Fast Food Restaurants, Rate (Per 100,000 Pop.) by County, 2011

- Over 100.0
- 75.1 - 100.0
- 50.1 - 75.0
- Under 50.1
- Under 50.1
- No Fast Food Restaurants
Grocery Store Access

This indicator reports the number of grocery stores per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>11</td>
<td>15.95</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>8</td>
<td>16.29</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>3</td>
<td>15.11</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>595</td>
<td>19.53</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>64,366</td>
<td>20.85</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

Grocery Stores and Supermarkets, Rate (Per 100,000 Pop.) by County, 2011

- Over 35.0
- 25.1 - 35.0
- 15.1 - 25.0
- Under 15.1
- No Grocery Stores
Liquor Store Access

This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>2</td>
<td>2.90</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>2</td>
<td>10.08</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>129</td>
<td>4.23</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>31,876</td>
<td>10.32</td>
</tr>
</tbody>
</table>

Establishment Rate per 100,000 Population

Report Area (2.90)
Iowa (4.23)
United States (10.32)

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

Beer, Wine and Liquor Stores, Rate (Per 100,000 Pop.) by County, 2011

- Over 18.0
- 12.1 - 18.0
- 6.1 - 12.0
- Under 6.1
- No Beer, Wine, or Liquor Stores
### Low Income Population with Low Food Access

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>4,574</td>
<td>6.63%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>3,705</td>
<td>7.54%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>869</td>
<td>4.38%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>199,383</td>
<td>6.54%</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>19,347,047</td>
<td>6.27%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average. No breakout data available.*


### Population with Limited Food Access, Low Income, Percent by Tract, 2010

- **Over 50.0%**
- **20.1 - 50.0%**
- **5.1 - 20.0%**
- **Under 5.1%**
- **No Low Food Access**
Park Access

This indicator reports the percentage of population living within 1/2 mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Population Within 1/2 Mile of a Park</th>
<th>Percent Population Within 1/2 Mile of a Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>35,841</td>
<td>52%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>27,504</td>
<td>56%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>8,336</td>
<td>42%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>1,355,581</td>
<td>44%</td>
</tr>
<tr>
<td>United States</td>
<td>312,732,537</td>
<td>120,503,664</td>
<td>39%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2010. Source geography: County.
Population with Low Food Access

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract (where a substantial number or share of residents has low access to a supermarket or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>17,234</td>
<td>24.99%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>13,727</td>
<td>27.95%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>3,507</td>
<td>17.67%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>691,782</td>
<td>22.71%</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>72,905,540</td>
<td>23.61%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Population with Limited Food Access, Percent by Tract, 2010

- Over 50.0%
- 20.1 - 50.0%
- 5.1 - 20.0%
- Under 5.1%
- No Low Food Access
Recreation and Fitness Facility Access

This indicator reports the number per 100,000 population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>10</td>
<td>14.50</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>8</td>
<td>16.29</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>2</td>
<td>10.08</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>347</td>
<td>11.39</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>29,506</td>
<td>9.56</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

Recreation and Fitness Facilities, Rate (Per 100,000 Pop.) by County, 2011

- Over 12.0
- 8.1 - 12.0
- 4.1 - 8.0
- Under 4.1
- No Fitness and Recreation Centers
SNAP-Authorized Food Store Access

This indicator reports the number of SNAP-authorized food stores as a rate per 100,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>SNAP-Authorized Retailers</th>
<th>SNAP-Authorized Retailers, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,811</td>
<td>60</td>
<td>87.20</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,015</td>
<td>42</td>
<td>85.69</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,796</td>
<td>18</td>
<td>90.93</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,062,309</td>
<td>2,773</td>
<td>90.55</td>
</tr>
<tr>
<td>United States</td>
<td>311,449,532</td>
<td>255,511</td>
<td>82.04</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


SNAP-Authorized Stores, Rate (Per 100,000 Pop.) by County, 2011

- Over 125.0
- 100.1 - 125.0
- 75.1 - 100.0
- Under 75.1
- No Data or Data Suppressed
Use of Public Transportation

This indicator reports the percentage of population using public transportation as their primary means of commute to work. Public transportation” includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>33,845</td>
<td>229</td>
<td>0.68</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>23,883</td>
<td>184</td>
<td>0.77</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>9,962</td>
<td>45</td>
<td>0.45</td>
</tr>
<tr>
<td>Iowa</td>
<td>1,524,370</td>
<td>17,239</td>
<td>1.13</td>
</tr>
<tr>
<td>United States</td>
<td>139,488,208</td>
<td>6,915,130</td>
<td>4.96</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Workers Traveling to Work Using Public Transit, Percent by County, 2007-11

- Over 1.0%
- 0.6 - 1.0%
- 0.1 - 0.5%
- 0.0%
WIC-Authorized Food Store Access

This indicator reports the number of food stores and other retail establishments per 100,000 population that are authorized to accept WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits and that carry designated WIC foods and food categories. This indicator is relevant because it provides a measure of food security and healthy food access for women and children in poverty as well as environmental influences on dietary behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (2011 Estimate)</th>
<th>Number WIC-Authorized Food Stores</th>
<th>WIC-Authorized Food Store Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,811</td>
<td>14</td>
<td>20.30</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,015</td>
<td>9</td>
<td>18.36</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,796</td>
<td>5</td>
<td>25.26</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,069,845</td>
<td>681</td>
<td>22.10</td>
</tr>
<tr>
<td>United States</td>
<td>318,921,538</td>
<td>50,042</td>
<td>15.60</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

WIC-Authorized Stores, Rate (Per 100,000 Pop.) by County, 2011

- Over 30.0
- 15.1 - 30.0
- Under 15.1
- No WIC-Authorized Retailers
- No Data or Data Suppressed
**Clinical Care**

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsurance, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access.

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

**Access to Primary Care**

This indicator reports the number of primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Primary Care Providers</th>
<th>Primary Care Provider Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>40</td>
<td>58</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>30</td>
<td>61.07</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>10</td>
<td>50.38</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>2,520</td>
<td>82.70</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>264,897</td>
<td>84.70</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: [U.S. Health Resources and Services Administration Area Resource File, 2011](#). Source geography: County.

**Primary Care Facilities, Rate (Per 100,000 Pop.) by County, 2011**

- Over 120.0
- 60.1 - 120.0
- 30.1 - 60.0
- 10.1 - 30.0
- Under 10.1
Breast Cancer Screening (Mammogram)

This indicator reports the percentage of female Medicare enrollees, age 67-69 or older, who have received one or more mammograms in the past two years. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Medicare Enrollees</th>
<th>Female Medicare Enrollees Age 67-69</th>
<th>Female Medicare Enrollees with Mammogram in Past 2 Years</th>
<th>Percent Female Medicare Enrollees with Mammogram in Past 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>9,430</td>
<td>718</td>
<td>486</td>
<td><strong>67.83%</strong></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>6,635</td>
<td>489</td>
<td>333</td>
<td><strong>68.30%</strong></td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>2,795</td>
<td>229</td>
<td>152</td>
<td><strong>66.81%</strong></td>
</tr>
<tr>
<td>Iowa</td>
<td>359,222</td>
<td>26,393</td>
<td>18,233</td>
<td><strong>69.09%</strong></td>
</tr>
<tr>
<td>United States</td>
<td>51,875,184</td>
<td>4,218,820</td>
<td>2,757,677</td>
<td><strong>65.37%</strong></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Patients with Mammogram in Past 2 Years, Percent of Female Medicare Enrollees, Age 67-69 by County, 2010

- **Over 72.0%**
- **64.1 - 72.0%**
- **56.1 - 64.0%**
- **Under 56.1%**
- No Data or Data Suppressed
Cervical Cancer Screening (Pap Test)

This indicator reports the percentage of women aged 18 and older who self-report that they have had a Pap test in the past three years. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Female Population Age 18</th>
<th>Estimated Population with Regular Pap Test</th>
<th>Percent Population with Regular Pap Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>27,260</td>
<td>22,294</td>
<td>81.78%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>19,494</td>
<td>15,576</td>
<td>79.90%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>7,766</td>
<td>6,718</td>
<td>86.50%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1,164,347</td>
<td>940,792</td>
<td>80.80%</td>
</tr>
<tr>
<td>United States</td>
<td>94,071,886</td>
<td>75,649,213</td>
<td>80.42%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Cervical Cancer Screening (Pap Test), Females Age 18, Percent by County, 2004-10

- Over 84.0%
- 80.1 - 84.0%
- 76.1 - 80.0%
- Under 76.1%
- No Data or Data Suppressed
Colon Cancer Screening (Sigmoid/Colonoscopy)

This indicator reports the percentage of adult men aged 50 and older who self-report that they have ever had a sigmoidoscopy or colonoscopy. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>11,502</td>
<td>4,597</td>
<td>57.79%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>7,954</td>
<td>4,597</td>
<td>57.80%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>3,548</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>453,720</td>
<td>251,361</td>
<td>55.40%</td>
</tr>
<tr>
<td>United States</td>
<td>41,994,838</td>
<td>24,124,869</td>
<td>57.45%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Colon Cancer Screening (Sigmoidoscopy / Colonoscopy), Adults Age 50, Percent by County, 2004-10

- Over 62.0%
- 55.1 - 62.0%
- 48.1 - 55.0%
- Under 48.1%
- No Data or Data Suppressed
Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year. This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Without Recent Dental Exam</th>
<th>Percent Adults with No Dental Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>15,410</td>
<td>29.25%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>12,970</td>
<td>34.65%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>2,440</td>
<td>16%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>591,664</td>
<td>25.64%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>70,965,788</td>
<td>30.15%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

6 or More Permanent Teeth Removed, Adults (Age 18), Percent by County, 2006-10

- Over 26.0%
- 20.1 - 26.0%
- 14.1 - 20.0%
- Under 14.1%
- No Data or Data Suppressed
Diabetes Management (Hemoglobin A1c Test)

This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Medicare Enrollees</th>
<th>Medicare Enrollees with Diabetes</th>
<th>Medicare Enrollees with Diabetes with Annual Exam</th>
<th>Percent Medicare Enrollees with Diabetes with Annual Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>9,430</td>
<td>1,074</td>
<td>948</td>
<td>88.36%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>6,635</td>
<td>751</td>
<td>655</td>
<td>87.35%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,795</td>
<td>323</td>
<td>292</td>
<td>90.71%</td>
</tr>
<tr>
<td>Iowa</td>
<td>359,222</td>
<td>36,958</td>
<td>32,973</td>
<td>89.22%</td>
</tr>
<tr>
<td>United States</td>
<td>51,875,184</td>
<td>6,218,804</td>
<td>5,212,097</td>
<td>83.81%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.  

Patients with Annual HA1C Test (Diabetes), Percent of Medicare Enrollees with Diabetes by County, 2010

- Over 88.0%
- 84.1 - 88.0%
- 80.1 - 84.0%
- Under 80.1%
- No Data or Data Suppressed
Facilities Designated as Health Professional Shortage Areas

This indicator reports the number and location of health care facilities designated as "Health Professional Shortage Areas" (HPSAs), defined as having shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Primary Care Facilities</th>
<th>Mental Health Care Facilities</th>
<th>Dental Health Care Facilities</th>
<th>Total HPSA Facility Designations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Iowa</td>
<td>62</td>
<td>50</td>
<td>52</td>
<td>164</td>
</tr>
<tr>
<td>United States</td>
<td>3,163</td>
<td>2,630</td>
<td>2,547</td>
<td>8,340</td>
</tr>
</tbody>
</table>

Note: No breakout data available.

Facilities Designated as HPSAs by Location, 2013-April

- Primary Care
- Mental Health
- Dental Care
Federally Qualified Health Centers

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Federally Qualified Health Centers</th>
<th>Rate of Federally Qualified Health Centers per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>58</td>
<td>1.90</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>5,402</td>
<td>1.73</td>
</tr>
</tbody>
</table>

Note: No breakout data available.

Federally Qualified Health Centers, Total 2012-Q4

- Federally Qualified Health Centers
High Blood Pressure Management

This indicator reports the percentage of adults aged 18 and older who self-report that they are not taking medication for their high blood pressure. This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health problems. When considered with other indicators of poor health, this indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Not Taking Blood Pressure Medication (When Needed)</th>
<th>Percent Adults Not Taking Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>15,313</td>
<td>29.07%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>15,313</td>
<td>40.91%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>441,847</td>
<td>19.15%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>51,175,402</td>
<td>21.74%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

HIV Screenings

This indicator reports the percentage of adults age 18-70 who self-report that they have never been screened for HIV. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Never Screened</th>
<th>Percent Adults Never Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>40,786</td>
<td>77.42%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>28,307</td>
<td>75.62%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>12,479</td>
<td>81.84%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>1,662,492</td>
<td>72.05%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>141,358,484</td>
<td>60.06%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Lack of a Consistent Source of Primary Care

This indicator reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider. This indicator is relevant because access to regular primary care is important to preventing major health issues and emergency department visits.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Without Any Regular Doctor</th>
<th>Percent Adults Without Any Regular Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>7,036</td>
<td>13.36%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>5,532</td>
<td>14.78%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>1,504</td>
<td>9.86%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>339,791</td>
<td>14.73%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>45,514,047</td>
<td>19.34%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Without Consistent Source of Primary Care, Adults (Age 18), Percent by County, 2006-10

- Over 35.0%
- 30.1 - 35.0%
- 25.1 - 30.0%
- Under 25.1%
- No Data or Data Suppressed
Pneumonia Vaccinations (Age 65)

This indicator reports the percentage of adults aged 65 and older who self-report that they have ever received a pneumonia vaccine. This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 65</th>
<th>Estimated Population with Annual Pneumonia Vaccination</th>
<th>Percent Population with Annual Pneumonia Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>11,810</td>
<td>5,358</td>
<td>65.60%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>8,168</td>
<td>5,358</td>
<td>65.60%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>3,642</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>99,097</td>
<td>68,773</td>
<td>69.40%</td>
</tr>
<tr>
<td>United States</td>
<td>15,659,860</td>
<td>10,389,527</td>
<td>66.34%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Annual Pneumonia Vaccination, Adults (Age 65), Percent by County, 2005-11

- Over 75.0%
- 70.1 - 75.0%
- 65.1 - 70.0%
- Under 65.1%
- No Data or Data Suppressed
Population Living in a Health Professional Shortage Area

This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>14,679</td>
<td>5,279</td>
<td>7.65%</td>
<td>35.96%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>14,679</td>
<td>5,279</td>
<td>10.75%</td>
<td>35.96%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>716,077</td>
<td>452,002</td>
<td>14.84%</td>
<td>63.12%</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>63,421,548</td>
<td>38,748,460</td>
<td>12.40%</td>
<td>61.10%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: U.S. Health Resources and Services Administration Data Warehouse, Health Professional Shortage Area (Components), May 2013.
Source geography: HPSA.

Health Professional Shortage Area Components, Percent Underserved (Primary Care) by Tract / County, May 2013

- Population Group; 100% Underserved
- Population Group; 50.1 - 99.9% Underserved
- Population Group; Under 50.1% Underserved
- Total Population; 100% Underserved
- Total Population; 50.1 - 99.9% Underserved
- Total Population; Under 50.1% Underserved
Preventable Hospital Events

This indicator reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This indicator is relevant because analysis of ACS discharges allows demonstrating a possible “return on investment” from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Medicare Part A Enrollees</th>
<th>Ambulatory Care Sensitive Condition Hospital Discharges</th>
<th>Ambulatory Care Sensitive Condition Discharge Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>10,436</td>
<td>708</td>
<td>67.92</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>6,889</td>
<td>520</td>
<td>75.51</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>3,547</td>
<td>188</td>
<td>53.18</td>
</tr>
<tr>
<td>Iowa</td>
<td>384,358</td>
<td>23,203</td>
<td>60.37</td>
</tr>
<tr>
<td>United States</td>
<td>56,167,590</td>
<td>3,737,659</td>
<td>66.54</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


![Ambulatory Care Sensitive Condition Discharge Rate Chart]

Ambulatory Care Sensitive Conditions, Rate (Per 1,000 Medicare Enrollees) by County, 2010

- Over 100.0
- 80.1 - 100.0
- 60.1 - 80.0
- Under 60.1
- No Data or Data Suppressed
HEALTH BEHAVIORS
Health behaviors such as poor diet, a lack of exercise, and substance abuse contribute to poor health status.

Alcohol Consumption

This indicator reports the percentage of adults aged 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day for men and one drink per day for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Heavily Consuming Alcohol</th>
<th>Percent Population Heavily Consuming Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>11,741</td>
<td>22.29%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>7,487</td>
<td>20%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>4,254</td>
<td>27.90%</td>
</tr>
<tr>
<td>Iowa</td>
<td>911,283</td>
<td>174,966</td>
<td>19.20%</td>
</tr>
<tr>
<td>United States</td>
<td>89,135,163</td>
<td>13,385,866</td>
<td>15.02%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Heavy Alcohol Consumption, Adults (Age 18), Percent by County, 2005-11

- Over 18.0%
- 13.1 - 18.0%
- 8.1 - 13.0%
- Under 8.1%
- No Data or Data Suppressed
Alcohol Expenditures

This indicator reports estimated expenditures for alcoholic beverages purchased at home, as a percentage of total household expenditures. This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Alcoholic Beverage Expenditures (USD)</th>
<th>Alcoholic Beverage Expenditures, County Rank (In-State)</th>
<th>Alcoholic Beverage Expenditures, County Percentile</th>
<th>Percent Alcoholic Beverage Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>45,638</td>
<td>902</td>
<td>no data</td>
<td>no data</td>
<td>1.98%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>no data</td>
<td>no data</td>
<td>79</td>
<td>79.80%</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>no data</td>
<td>no data</td>
<td>32</td>
<td>32.32%</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>908</td>
<td>no data</td>
<td>no data</td>
<td>1.87%</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>910</td>
<td>no data</td>
<td>no data</td>
<td>1.79%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Alcoholic Beverage Expenditures, Ranked Percent of Total Expenditures by Tract, 2011

- Top 80th Percentile (Highest Expenditures)
- 60th - 80th Percentile
- 40th - 60th Percentile
- 20th - 40th Percentile
- Bottom 20th Percentile (Lowest Expenditures)
- No Data or Data Suppressed
Fruit/Vegetable Consumption

This indicator reports the percentage of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may illustrate a cause of significant health issues, such as obesity and diabetes.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population with Inadequate Fruit / Vegetable Consumption</th>
<th>Percent Population with Inadequate Fruit / Vegetable Consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,522</td>
<td>44,267</td>
<td>84.28%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,298</td>
<td>31,890</td>
<td>85.50%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,224</td>
<td>12,377</td>
<td>81.30%</td>
</tr>
<tr>
<td>Iowa</td>
<td>896,432</td>
<td>723,421</td>
<td>80.70%</td>
</tr>
<tr>
<td>United States</td>
<td>116,676,632</td>
<td>88,508,989</td>
<td>75.86%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Inadequate Fruit/Vegetable Consumption, Adults (Age 18), Percent by County, 2005-09

- Over 85.0%
- 80.1 - 85.0%
- 75.1 - 80.0%
- Under 75.1%
- No Data or Data Suppressed
Fruit/Vegetable Expenditures

This indicator reports estimated expenditures for fruits and vegetables purchased for in-home consumption, as a percentage of total household expenditures. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may illustrate a cause of significant health issues, such as obesity and diabetes.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Fruit / Vegetable Expenditures (USD)</th>
<th>Fruit / Vegetable Expenditures, County Rank (In-State)</th>
<th>Percent Fruit / Vegetable Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>45,638</td>
<td>642</td>
<td>no data</td>
<td>1.41%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>no data</td>
<td>no data</td>
<td>62</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>no data</td>
<td>no data</td>
<td>67</td>
<td>62.63%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>634</td>
<td>no data</td>
<td>1.30%</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>737</td>
<td>no data</td>
<td>1.45%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Fruit and Vegetable Expenditures, Ranked Percent of Total Expenditures by Tract, 2011

- Top 80th Percentile (Highest Expenditures)
- 60th - 80th Percentile
- 40th - 60th Percentile
- 20th - 40th Percentile
- Bottom 20th Percentile (Lowest Expenditures)
- No Data or Data Suppressed
Physical Inactivity (Adult)

This indicator reports the percentage of adults aged 20 and older who self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 20</th>
<th>Population with no Leisure Time Physical Activity</th>
<th>Percent Population with no Leisure Time Physical Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>50,793</td>
<td>14,604</td>
<td>27.17%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>36,079</td>
<td>10,896</td>
<td>28.70%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>14,714</td>
<td>3,708</td>
<td>23.50%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,201,272</td>
<td>555,843</td>
<td>24.49%</td>
</tr>
<tr>
<td>United States</td>
<td>223,602,200</td>
<td>53,553,398</td>
<td>23.67%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Soda Expenditures

This indicator reports soft drink consumption by census tract by estimating expenditures for carbonated beverages, as a percentage of total household expenditures. This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues such as diabetes and obesity.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Soda Expenditures (USD)</th>
<th>Soda Expenditures, County Rank (In-State)</th>
<th>Soda Expenditures, County Percentile</th>
<th>Percent Soda Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>45,638</td>
<td>266</td>
<td>no data</td>
<td>no data</td>
<td>0.58%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>no data</td>
<td>no data</td>
<td>74</td>
<td>74.75%</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>no data</td>
<td>no data</td>
<td>73</td>
<td>73.74%</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>271</td>
<td>no data</td>
<td>no data</td>
<td>0.56%</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>252</td>
<td>no data</td>
<td>no data</td>
<td>0.49%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: [Nielsen Claritas Site Reports, Consumer Buying Power, 2011](#). Source geography: Tract.

![Soda Expenditures, Ranked Percent of Total Expenditures by Tract, 2011](image)

Legend:
- **Top 80th Percentile (Highest Expenditures)**
- **60th - 80th Percentile**
- **40th - 60th Percentile**
- **20th - 40th Percentile**
- **Bottom 20th Percentile (Lowest Expenditures)**
- **No Data or Data Suppressed**
Tobacco Expenditures

This indicator reports estimated expenditures for cigarettes, as a percentage of total household expenditures. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Cigarette Expenditures (USD)</th>
<th>Cigarette Expenditures, County Rank (In-State)</th>
<th>Cigarette Expenditures, County Percentile</th>
<th>Percent Cigarette Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>45,638</td>
<td>1,042</td>
<td>no data</td>
<td>no data</td>
<td>2.28%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>no data</td>
<td>no data</td>
<td>73</td>
<td>73.74%</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>no data</td>
<td>no data</td>
<td>87</td>
<td>87.88%</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>981</td>
<td>no data</td>
<td>no data</td>
<td>2.02%</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>810</td>
<td>no data</td>
<td>no data</td>
<td>1.59%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Cigarette Expenditures, Ranked Percent of Total Expenditures by Tract, 2011

- Top 80th Percentile (Highest Expenditures)
- 60th - 80th Percentile
- 40th - 60th Percentile
- 20th - 40th Percentile
- Bottom 20th Percentile (Lowest Expenditures)
- No Data or Data Suppressed
Tobacco Usage (Current Smokers)

This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Regularly Smoking Cigarettes</th>
<th>Percent Estimated Population Regularly Smoking Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>12,187</td>
<td>23.13%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>10,632</td>
<td>28.40%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>1,555</td>
<td>10.20%</td>
</tr>
<tr>
<td>Iowa</td>
<td>911,283</td>
<td>167,676</td>
<td>18.40%</td>
</tr>
<tr>
<td>United States</td>
<td>207,962</td>
<td>20,796</td>
<td>10%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Smoking Cigarettes Some Days or Ever Day, Adults Age 18, Percent by County, 2005-11

- Over 26.0%
- 22.1 - 26.0%
- 18.1 - 22.0%
- Under 18.1%
- No Data or Data Suppressed
Tobacco Usage (Former or Current Smokers)

This indicator reports the percentage of adults smoking at least 100 cigarettes in his / her lifetimes.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Ever Smoking 100 or More Cigarettes</th>
<th>Percent Adults Ever Smoking 100 or More Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>20,299</td>
<td>54.22%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>4,199</td>
<td>27.54%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>982,375</td>
<td>42.57%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>101,180,961</td>
<td>42.99%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Ever Smoking > 99 Cigarettes, Adults (Age 18), Percent by County, 2006-10

- Over 52.0%
- 46.1 - 52.0%
- 40.1 - 46.0%
- Under 40.1%
- No Data or Data Suppressed
Tobacco Usage (Quit Attempt)

This indicator reports the percentage of adult smokers who attempted to quit smoking for at least 1 day in the past 1 year.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Smokers with Quit Attempt in Past 12 Months</th>
<th>Percent Smokers with Quit Attempt in Past 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>24,333</td>
<td>46.19%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>24,333</td>
<td>65%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>1,230,069</td>
<td>53.31%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>137,674,809</td>
<td>58.49%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Smokers Who Quit / Attempted to Quit in Past 12 Months, Adults (Age 18), Percent by County, 2006-10

- Over 64.0%
- 58.1 - 64.0%
- 52.1 - 58.0%
- Under 52.1%
- No Data or Data Suppressed
**HEALTH OUTCOMES**

Measuring morbidity and mortality rates allows assessing linkages between social determinants of health and outcomes. By comparing, for example, the prevalence of certain chronic diseases to indicators in other categories (e.g., poor diet and exercise) with outcomes (e.g., high rates of obesity and diabetes), various causal relationship may emerge, allowing a better understanding of how certain community health needs may be addressed.

**Accident Mortality**

This indicator reports the rate of death due to unintentional injury (accident) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because accidents are a leading cause of death in the U.S.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Accident Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>26</td>
<td>37.56</td>
<td>34.57</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>19</td>
<td>37.74</td>
<td>34.43</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>7</td>
<td>37.11</td>
<td>34.90</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>1,247</td>
<td>41.35</td>
<td>37.05</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>121,217</td>
<td>39.89</td>
<td>39.07</td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;= 36.0</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.

**Unintentional Injury (Accident) Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10**

- Over 69.0
- 57.1 - 69.0
- 48.1 - 57.0
- 40.1 - 48.0
- Under 40.1
- No Data or Data Suppressed
### Population by Gender, Accident Mortality, Age-Adjusted Rate (Per 100,000 Pop.)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>47.90</td>
<td>21</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>46.21</td>
<td>22.05</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>52.03</td>
<td>18.38</td>
</tr>
<tr>
<td>Iowa</td>
<td>51.04</td>
<td>24.36</td>
</tr>
<tr>
<td>United States</td>
<td>53.82</td>
<td>25.53</td>
</tr>
</tbody>
</table>
Asthma Prevalence

This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma. This indicator is relevant because asthma is a prevalent problem in the U.S. that is often exacerbated by poor environmental conditions.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults with Asthma</th>
<th>Percent Adults with Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>6,583</td>
<td><strong>12.50%</strong></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>5,451</td>
<td><strong>14.56%</strong></td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>1,132</td>
<td><strong>7.42%</strong></td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>242,876</td>
<td><strong>10.53%</strong></td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>31,061,484</td>
<td><strong>13.20%</strong></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Ever Diagnosed with Asthma, Adults (Age 18), Percent by County, 2006-10

- Over 16.0%
- 13.1 - 16.0%
- 10.1 - 13.0%
- Under 10.1%
- No Data or Data Suppressed
Breast Cancer Incidence

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of females with breast cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Cancer Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate, Breast Cancer (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,021</td>
<td>84</td>
<td>121.70</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,129</td>
<td>63</td>
<td><strong>128.30</strong></td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,892</td>
<td>21</td>
<td><strong>105.90</strong></td>
</tr>
<tr>
<td>Iowa</td>
<td>2,978,880</td>
<td>3,679</td>
<td>123.50</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>367,783</td>
<td>122</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Breast Cancer Incidence, Rate (Per 100,000 Pop.) by County, 2005-09

- Over 128.0
- 117.1 - 128.0
- 103.1 - 117.0
- Under 103.1
- No Data or Data Suppressed
Cancer Mortality

This indicator reports the rate of death due to malignant neoplasm (cancer) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because cancer is a leading cause of death in the United States.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Cancer Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>169</td>
<td>244.72</td>
<td>182.77</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>121</td>
<td>245.95</td>
<td>186.81</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>48</td>
<td>241.69</td>
<td>172.78</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>6,353</td>
<td>210.68</td>
<td>175.03</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>566,121</td>
<td>186.32</td>
<td>176.66</td>
</tr>
</tbody>
</table>

HP 2020 Target

Note: This indicator is compared with the Healthy People 2020 Target.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER, Source geography: County.

Cancer Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 270.0
- 240.1 - 270.0
- 215.1 - 240.0
- 180.1 - 215.0
- Under 180.1
- No Data or Data Suppressed
### Population by Gender, Cancer Mortality, Age-Adjusted Rate (Per 100,000 Pop.)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>226.43</td>
<td>151.67</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>226.75</td>
<td>157.99</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>225.64</td>
<td>135.89</td>
</tr>
<tr>
<td>Iowa</td>
<td>213.04</td>
<td>149.27</td>
</tr>
<tr>
<td>United States</td>
<td>215.04</td>
<td>150.05</td>
</tr>
</tbody>
</table>

![Bar Chart](chart.png)
Chlamydia Incidence

This indicator reports incidence rate of chlamydia cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, 2010 Census</th>
<th>Reported Cases of Chlamydia</th>
<th>Chlamydia Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>195</td>
<td>282.76</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>158</td>
<td>322.80</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>37</td>
<td>185.30</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>9,406</td>
<td>313.26</td>
</tr>
<tr>
<td>United States</td>
<td>308,730,677</td>
<td>1,236,680</td>
<td>406.89</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Chlamydia Rate (Per 100,000 Pop.)

- Report Area (282.76)
- Iowa (313.26)
- United States (406.89)

Chlamydia Infections, Rate (Per 100,000 Pop.) by County, 2010

- Over 500.0
- 300.1 - 500.0
- 200.1 - 300.0
- 100.1 - 200.0
- Under 100.1
Colon and Rectum Cancer Incidence

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Cancer Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate, Colon and Rectum Cancer (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,021</td>
<td>39</td>
<td>56.50</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,129</td>
<td>27</td>
<td>54.80</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,892</td>
<td>12</td>
<td>58.80</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,978,880</td>
<td>1,552</td>
<td>52.10</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>121,188</td>
<td>40.20</td>
</tr>
<tr>
<td>HP 2020 Target</td>
<td></td>
<td></td>
<td>&lt;= 38.6</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target.

Colorectal Cancer Incidence, Rate (Per 100,000 Pop.) by County, 2005-09
Diabetes Prevalence

This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 20</th>
<th>Population with Diagnosed Diabetes</th>
<th>Percent Population with Diagnosed Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>50,886</td>
<td>4,296</td>
<td>7.09%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>36,235</td>
<td>3,080</td>
<td>7.30%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>14,651</td>
<td>1,216</td>
<td>6.60%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,200,735</td>
<td>182,018</td>
<td>7.42%</td>
</tr>
<tr>
<td>United States</td>
<td>223,653,607</td>
<td>20,615,282</td>
<td>8.72%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Diagnosed With Diabetes, Adults (Age 20), Percent by County, 2009

- Over 10.5%
- 9.1 - 10.5%
- 7.6 - 9.0%
- Under 7.6%
Gonorrhea Incidence

This indicator reports incidence rate of Gonorrhea cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Population Age 18</th>
<th>Gonorrhea Infections</th>
<th>Gonorrhea Infection Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,964</td>
<td>23</td>
<td>33.35</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,116</td>
<td>22</td>
<td>44.80</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,848</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>1,803</td>
<td>59.19</td>
</tr>
<tr>
<td>United States</td>
<td>308,744,685</td>
<td>307,929</td>
<td>99.74</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: Centers for Disease Control and Prevention and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2010. Source geography: County.

Gonorrhea Infections, Rate (Per 100,000 Pop.) by County, 2010

- Over 100.0
- 30.1 - 100.0
- 10.1 - 30.0
- Under 10.1
- No Cases
Heart Disease Mortality

This indicator reports the rate of death due to coronary heart disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because heart disease is a leading cause of death in the United States.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Heart Disease Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>214</td>
<td>308.57</td>
<td>209.74</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>157</td>
<td>319</td>
<td>220.59</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>56</td>
<td>282.81</td>
<td>182.94</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>5,528</td>
<td>183.31</td>
<td>141.55</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>432,552</td>
<td>142.36</td>
<td>134.65</td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>&lt;= 100.8</strong></td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the Healthy People 2020 Target.*

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.

Heart Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 220.0
- 180.1 - 220.0
- 150.1 - 180.0
- 120.1 - 150.0
- Under 120.1
- No Data or Data Suppressed
<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>251.80</td>
<td>177.02</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>260.08</td>
<td>189.37</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>231.53</td>
<td>146.20</td>
</tr>
<tr>
<td>Iowa</td>
<td>187.31</td>
<td>106.66</td>
</tr>
<tr>
<td>United States</td>
<td>175</td>
<td>103.44</td>
</tr>
</tbody>
</table>
Heart Disease Prevalence

This indicator reports the percentage of adults aged 18 and older who have ever been told by a doctor that they have coronary heart disease or angina. This indicator is relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults with Heart Disease</th>
<th>Percent Adults with Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>3,234</td>
<td>6.14%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>2,280</td>
<td>6.09%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>954</td>
<td>6.26%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>94,038</td>
<td>4.08%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>10,183,713</td>
<td>4.33%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Ever Diagnosed with Angina or Heart Disease, Adults (Age 18), Percent by County, 2006-10

- Over 6.0%
- 4.6 - 6.0%
- 3.1 - 4.5%
- Under 3.1%
- No Data or Data Suppressed
HIV Prevalence

This indicator reports prevalence rate of HIV per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Population Age 18</th>
<th>Population with HIV</th>
<th>HIV Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,769</td>
<td>20</td>
<td>37.90</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,526</td>
<td>20</td>
<td>53.60</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,243</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,318,362</td>
<td>1,507</td>
<td>65</td>
</tr>
<tr>
<td>United States</td>
<td>234,564,075</td>
<td>724,515</td>
<td>308.88</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

HIV Prevalence Rate

- **Report Area (37.90)**
- **Iowa (65)**
- **United States (308.88)**

**HIV Prevalence, Rate (Per 100,000 Pop.) by County, 2009**

- Over 200.0
- 100.1 - 200.0
- 50.1 - 100.0
- Under 50.1
- No Data or Data suppressed
Infant Mortality

This indicator reports the rate of deaths to infants less than one year of age per 1,000 births. This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Births</th>
<th>Total Infant Deaths</th>
<th>Infant Mortality Rate (Per 1,000 Births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>5,702</td>
<td>39</td>
<td>6.84</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>4,231</td>
<td>39</td>
<td>9.22</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>1,471</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>277,341</td>
<td>1,463</td>
<td>5.28</td>
</tr>
<tr>
<td>United States</td>
<td>58,600,996</td>
<td>393,074</td>
<td>6.71</td>
</tr>
</tbody>
</table>

**HP 2020 Target**

<= 6.0

Note: This indicator is compared with the Healthy People 2020 Target.


Infant Mortality, Rate (Per 1,000 Live Births) by County, 2003-09

- Over 9.0
- 7.1 - 9.0
- 6.1 - 7.0
- Under 6.1
- No Data or Data Suppressed
Low Birth Weight

This indicator reports the percentage of total births that were low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Births</th>
<th>Number Low Birth Weight (&lt; 2500g)</th>
<th>Percent Low Birth Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>5,692</td>
<td>443</td>
<td>7.78%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>4,230</td>
<td>349</td>
<td>8.25%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>1,462</td>
<td>94</td>
<td>6.43%</td>
</tr>
<tr>
<td>Iowa</td>
<td>275,030</td>
<td>18,780</td>
<td>6.83%</td>
</tr>
<tr>
<td>United States</td>
<td>29,126,451</td>
<td>2,359,843</td>
<td>8.10%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Low Birth Weight, Rate by County, 2002-08

- Over 10.0%
- 8.6 - 10.0%
- 7.1 - 8.5%
- 5.6 - 7.0%
- Under 5.6%
Lung Cancer Incidence

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of lung cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Cancer Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate, Lung Cancer (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,021</td>
<td>46</td>
<td>66.60</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,129</td>
<td>33</td>
<td>67.80</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,892</td>
<td>13</td>
<td>64</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,978,880</td>
<td>2,070</td>
<td>69.40</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>202,582</td>
<td>67.20</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Lung Cancer Incidence, Rate (Per 100,000 Pop.) by County, 2005-09

- Over 86.0
- 76.1 - 86.0
- 65.1 - 76.0
- Under 65.1
- No Data or Data Suppressed
Lung Disease Mortality

This indicator reports the rate of death due to chronic lower respiratory disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because lung disease is a leading cause of death in the United States.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Lung Disease Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>40</td>
<td>57.79</td>
<td>40.46</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>28</td>
<td>56.01</td>
<td>39.96</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>12</td>
<td>62.18</td>
<td>41.68</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>1,739</td>
<td>57.65</td>
<td>46.50</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>133,806</td>
<td>44.04</td>
<td>42.40</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER, Source geography: County.

Lung Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 80.0
- 65.1 - 80.0
- 54.1 - 65.0
- 42.1 - 54.0
- Under 42.1
- No Data or Data Suppressed
### Population by Gender, Lung Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>47.25</td>
<td>36.96</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>43.75</td>
<td>39.46</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>55.81</td>
<td>30.73</td>
</tr>
<tr>
<td>Iowa</td>
<td>59.63</td>
<td>38.68</td>
</tr>
<tr>
<td>United States</td>
<td>49.56</td>
<td>37.82</td>
</tr>
</tbody>
</table>
Motor Vehicle Crash Death

This indicator reports the rate of death due to motor vehicle crashes per 100,000 population, which include collisions with another motor vehicle, a non-motorist, a fixed object, and a non-fixed object, an overturn, and any other non-collision. This indicator is relevant because motor vehicle crash deaths are preventable and they are a cause of premature death.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Annual Deaths, 2006-2010 Average</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Motor Vehicle Crash Death (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>10</td>
<td>14.74</td>
<td>15.09</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>7</td>
<td>15.02</td>
<td>14.55</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>3</td>
<td>14.04</td>
<td>16.43</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>428</td>
<td>14.19</td>
<td>13.84</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>40,120</td>
<td>13.20</td>
<td>13.04</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.

Motor Vehicle Accident Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 30.0
- 23.1 - 30.0
- 18.1 - 23.0
- 13.1 - 18.0
- Under 13.1
- No Data or Data Suppressed
Obesity (Adult)

This indicator reports the percentage of adults aged 20 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese). This indicator is relevant because excess weight is a prevalent problem in the U.S.; it indicates an unhealthy lifestyle and puts individuals at risk for further health issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 20</th>
<th>Population with BMI &gt; 30.0 (Obese)</th>
<th>Percent Population with BMI &gt; 30.0 (Obese)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>50,847</td>
<td>15,431</td>
<td>30.20%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>36,113</td>
<td>10,834</td>
<td>29.80%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>14,734</td>
<td>4,597</td>
<td>31.20%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,200,901</td>
<td>639,219</td>
<td>28.97%</td>
</tr>
<tr>
<td>United States</td>
<td>223,576,989</td>
<td>61,460,308</td>
<td>27.35%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Obese (BMI >= 30), Adults (Age 20), Percent by County, 2009

- Over 33.0%
- 30.6 - 33.0%
- 28.1 - 30.5%
- Under 28.1%
## Adult Obesity by Gender

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Males Obese</th>
<th>Percent Males Obese</th>
<th>Total Females Obese</th>
<th>Percent Females Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>8,174</td>
<td>33.02%</td>
<td>7,258</td>
<td>27.43%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>5,721</td>
<td>32.70%</td>
<td>5,114</td>
<td>27%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>2,453</td>
<td>33.80%</td>
<td>2,144</td>
<td>28.50%</td>
</tr>
<tr>
<td>Iowa</td>
<td>335,279</td>
<td>31.09%</td>
<td>303,940</td>
<td>26.91%</td>
</tr>
<tr>
<td>United States</td>
<td>31,008,901</td>
<td>28.30%</td>
<td>30,451,365</td>
<td>26.37%</td>
</tr>
</tbody>
</table>

![Graph showing adult obesity by gender](image-url)
Overweight (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight). This indicator is relevant because excess weight is a prevalent problem in the U.S.; it indicates an unhealthy lifestyle and puts individuals at risk for further health issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Overweight</th>
<th>Percent Adults Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>20,160</td>
<td>38.27%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>14,541</td>
<td>38.84%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>5,619</td>
<td>36.85%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>866,169</td>
<td>37.54%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>85,495,735</td>
<td>36.32%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Population Overweight (BMI 25.0-29.9), Adults (Age 18), Percent by County, 2006-10

- Over 39.0%
- 36.1 - 39.0%
- 33.1 - 36.0%
- Under 33.1%
- No Data or Data Suppressed
Pedestrian Motor Vehicle Death

This indicator reports the rate of pedestrians killed by motor vehicles per 100,000 population. This indicator is relevant because pedestrian-motor vehicle crash deaths are preventable and they are a cause of premature death.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Deaths, 2008-2010</th>
<th>Average Annual Deaths, 2008-2010</th>
<th>Average Annual Death Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Iowa</td>
<td>55</td>
<td>18</td>
<td><strong>0.60</strong></td>
</tr>
<tr>
<td>United States</td>
<td>12,750</td>
<td>4,250</td>
<td><strong>1.38</strong></td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td>&lt;= 1.3</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target. No breakout data available.


Pedestrian Motor Vehicle Accident Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2008-10:
- Over 2.5%
- 1.6 - 2.5%
- 1.1 - 1.5%
- Under 1.1%
- No Deaths
Poor Dental Health

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults with Poor Dental Health</th>
<th>Percent Adults with Poor Dental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>13,941</td>
<td>26.46%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>9,310</td>
<td>24.87%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>4,631</td>
<td>30.37%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,307,562</td>
<td>341,535</td>
<td>14.80%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>36,842,620</td>
<td>15.65%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Without Dental Exam in Past 12 Months, Adults (Age 18), Percent by County, 2006-10

- Over 42.0%
- 34.1 - 42.0%
- 26.1 - 34.0%
- Under 26.1%
- No Data or Data Suppressed
Poor General Health

This indicator reports the percentage of adults age 18 and older who self-report having poor or fair health. This indicator is relevant because it is a measure of general poor health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population with Poor or Fair Health</th>
<th>Percent Population with Poor or Fair Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>52,683</td>
<td>7,987</td>
<td><strong>15.16%</strong></td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>37,435</td>
<td>5,990</td>
<td><strong>16%</strong></td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>15,248</td>
<td>1,997</td>
<td><strong>13.10%</strong></td>
</tr>
<tr>
<td>Iowa</td>
<td>2,292,276</td>
<td>259,027</td>
<td><strong>11.30%</strong></td>
</tr>
<tr>
<td>United States</td>
<td>229,932,154</td>
<td>36,429,871</td>
<td><strong>15.84%</strong></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Population with Poor or Fair Health, Adults (Age 18), Percent by County, 2005-11

- Over 22.0%
- 16.1 - 22.0%
- 10.1 - 16.0%
- Under 10.1%
- No Data or Data Suppressed
Population with Any Disability

This indicator reports the percentage of the total civilian non-institutionalized population with a disability. This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Population for Whom Disability Status Is Determined</th>
<th>Total Population with a Disability</th>
<th>Percent Population with a Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,922</td>
<td>8,931</td>
<td>12.96%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,094</td>
<td>6,423</td>
<td>13.19%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,828</td>
<td>2,508</td>
<td>12.79%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,048,461</td>
<td>338,835</td>
<td>11.11%</td>
</tr>
<tr>
<td>United States</td>
<td>309,231,232</td>
<td>36,499,048</td>
<td>12%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Data Source: U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates. Source geography: PUMA.

Disabled Population, Percent by PUMA, 2009-11

- Over 15.0%
- 12.1 - 15.0%
- 9.1 - 12.0%
- Under 9.1%
### Population with Any Disability by Age Group, Percent

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Under Age 18</th>
<th>Age 18 - 64</th>
<th>Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>6.09%</td>
<td>9.42%</td>
<td>35.70%</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>6.56%</td>
<td>9.17%</td>
<td>37.40%</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>4.89%</td>
<td>10.05%</td>
<td>31.86%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3.90%</td>
<td>9.12%</td>
<td>33.01%</td>
</tr>
<tr>
<td>United States</td>
<td>3.98%</td>
<td>10.02%</td>
<td>36.79%</td>
</tr>
</tbody>
</table>

![Population with Any Disability by Age Group](image-url)
Premature Death

This indicator reports Years of Potential Life Lost (YPLL) before age 75 per 100,000 population for all causes of death, age-adjusted to the 2000 standard. YPLL measures premature death and is calculated by subtracting the age of death from the 75 year benchmark. This indicator is relevant because a measure of premature death can provide a unique and comprehensive look at overall health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, 2008-2010 Average</th>
<th>Total Premature Deaths, 2008-2010 Average</th>
<th>Total Years of Potential Life Lost, 2008-2010 Average</th>
<th>Years of Potential Life Lost, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>68,811</td>
<td>267</td>
<td>4,430</td>
<td>6,437</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,015</td>
<td>192</td>
<td>3,246</td>
<td>6,622</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,796</td>
<td>74</td>
<td>1,184</td>
<td>5,979</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,062,309</td>
<td>10,015</td>
<td>184,182</td>
<td>6,014</td>
</tr>
<tr>
<td>United States</td>
<td>311,616,188</td>
<td>1,074,667</td>
<td>21,327,690</td>
<td>6,851</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


Premature Deaths, Years Lost Rate (Per 100,000 Pop.) by County, 2008-10

- Over 10,000
- 8,001 - 10,000
- 6,001 - 8,000
- Under 6,000
- No Data or Data Suppressed
Prostate Cancer Incidence

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of males with prostate cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 2005-2009</th>
<th>Annual Cancer Incidence, 2005-2009 Average</th>
<th>Annual Incidence Rate, Prostate Cancer (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,021</td>
<td>92</td>
<td>133.20</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,129</td>
<td>65</td>
<td>133</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,892</td>
<td>27</td>
<td>137.90</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,978,880</td>
<td>4,235</td>
<td>142.10</td>
</tr>
<tr>
<td>United States</td>
<td>301,461,536</td>
<td>456,412</td>
<td>151.40</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Prostate Cancer Incidence, Rate (Per 100,000 Pop.) by County, 2005-09

- Over 167.0
- 145.1 - 167.0
- 125.1 - 145.0
- Under 125.1
- No Data or Data Suppressed
Stroke Mortality

This indicator reports the rate of death due to cerebrovascular disease (stroke) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because stroke is a leading cause of death in the United States.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Stroke Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>41</td>
<td>59.52</td>
<td>40.55</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>29</td>
<td>59.66</td>
<td>41.01</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>12</td>
<td>59.17</td>
<td>39.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>1,662</td>
<td>55.10</td>
<td>41.81</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>133,107</td>
<td>43.81</td>
<td>41.78</td>
</tr>
<tr>
<td>HP 2020 Target</td>
<td></td>
<td></td>
<td></td>
<td>&lt;= 33.8</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER, Source geography: County.

Stroke Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 73.0
- 60.1 - 73.0
- 51.1 - 60.0
- 41.1 - 51.0
- Under 41.1
- No Data or Data Suppressed
### Population by Gender, Stroke Mortality, Age-Adjusted Rate (Per 100,000 Pop.)

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>42.50</td>
<td>36.82</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>46.45</td>
<td>34.71</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>32.82</td>
<td>42.08</td>
</tr>
<tr>
<td>Iowa</td>
<td>42.52</td>
<td>40.44</td>
</tr>
<tr>
<td>United States</td>
<td>41.95</td>
<td>40.96</td>
</tr>
</tbody>
</table>
Suicide

This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Suicide (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>69,222</td>
<td>9</td>
<td>13.58</td>
<td>14.60</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>49,279</td>
<td>7</td>
<td>13.80</td>
<td>14.17</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>19,943</td>
<td>3</td>
<td>13.04</td>
<td>15.65</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,015,563</td>
<td>354</td>
<td>11.73</td>
<td>11.70</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>35,841</td>
<td>11.80</td>
<td>11.57</td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;= 10.2</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target.

Suicide Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, 2006-10

- Over 19.0
- 15.1 - 19.0
- 13.1 - 15.0
- 11.1 - 13.0
- Under 11.1
- No Data or Data Suppressed
<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>25.39</td>
<td>no data</td>
</tr>
<tr>
<td>Clinton County, IA</td>
<td>24.09</td>
<td>no data</td>
</tr>
<tr>
<td>Jackson County, IA</td>
<td>28.56</td>
<td>no data</td>
</tr>
<tr>
<td>Iowa</td>
<td>19.24</td>
<td>4.48</td>
</tr>
<tr>
<td>United States</td>
<td>18.96</td>
<td>4.77</td>
</tr>
</tbody>
</table>
Demographic & Social Indicators

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. Total population counts are reported in the ACS public use files by combined race and ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Total Population
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{[\text{Subgroup Population}]}{[\text{Total Population}]} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).
Median Age

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Median age data acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Data are summarized by the U.S. Census Bureau to 2010 census tract boundaries. Data provided by the census are area estimates; as a median, this indicator cannot be resummarized or recalculated.

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2010 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

Population Under Age 18

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.
Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

Population Age 18-64
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.
Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

Population Age 65+
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: *U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).*
For more information about this source, including data collection methodology and definitions, refer to the [American Community Survey](https://www.census.gov) website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete [American Community Survey 2011 Subject Definitions](https://www.census.gov/programs-surveys/acs/2011-subject-definitions.html).

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

Hispanic Population
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to
produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

_Citation_: [U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008)](https://www.census.gov/acs/www/). For more information about this source, including data collection methodology and definitions, refer to the [American Community Survey](https://www.census.gov/acs/www/) website.

**Methodology**
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete [American Community Survey 2011 Subject Definitions](https://www.census.gov/acs/www/sfd/sstodes.html).

**Data Limitations**
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

**Foreign-Born Population**

**Data Background**
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

_Citation_: [U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008)](https://www.census.gov/acs/www/). For more information about this source, including data collection methodology and definitions, refer to the [American Community Survey](https://www.census.gov/acs/www/) website.

**Methodology**
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:
Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the language universe (for example, people living in group homes or those living in agriculture workers’ dormitories) may have different levels of English proficiency than the general population. Direct comparisons of the data would likely result in erroneous conclusions about the English language proficiency of all people living in the area.

Linguistically Isolated Households
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the language universe (for example, people living in group homes or those living in agriculture workers’ dormitories) may have different levels of English proficiency than the general population. Direct comparisons of the data would likely result in erroneous conclusions about the English language proficiency of all people living in the area.

Linguistically Isolated Households
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.
replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the language universe (for example, people living in group homes or those living in agriculture workers’ dormitories) may have different levels of English proficiency than the general population. Direct comparisons of the data would likely result in erroneous conclusions about the English language proficiency of all people living in the area.

Population Geographic Mobility
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population using the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the specific data elements reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Urban and Rural Population

Data Background

The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The census collects information about the age, sex, race, and ethnicity of every person in the United States. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in federal funds to local communities. For more information about this source, refer to the United States Census 2010 website.

Methodology

Data are from the US 2010 Decennial Census, which provides urban and rural attributes for all geographic areas. by the 2010 Census definition, urban areas are comprised of a densely settled core of census tracts and/or census blocks that meet minimum population density requirements and/or land use requirements. The Census Bureau identifies two types of urban areas:

- Urbanized Areas (UAs) of 50,000 or more people;
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

To qualify as an urban area, the territory identified according to criteria must encompass at least 2,500 people, at least 1,500 of which reside outside institutional group quarters. Areas adjacent to urban areas and cores are also designated as urban when they are non-residential, but contain urban land uses, or when they contain low population, but link outlying densely settled territory with the densely settled core.

"Rural" areas consist of all territory, population, and housing units located outside UAs and UCs. Geographic entities, such as metropolitan areas, counties, minor civil divisions, places, and census tracts, often contain both urban and rural territory, population, and housing units. Indicator data tables display the percentage of population in areas designated either urban or rural based on the following formula:

\[
\text{Percentage} = \frac{\text{Urban or Rural Population}}{\text{Total Population}} \times 100
\]

For more information, please visit the US Census Bureau’s 2010 Urban and Rural Classification web page.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the US Decennial Census based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the 2010 Census are: White, Black, American Indian/Alaskan Native, Asian, and Other. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity.
Adequate Social or Emotional Support

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “… a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following question:

"How often do you get the social and emotional support you need?"

This indicator represents the percentage of those persons who answered that they do not receive adequate social/emotional support all or most of the time. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[ \text{Persons with Inadequate Support} = \left( \frac{\text{Indicator Percentage}}{100} \right) \times \text{Total Population} \]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.
Children Eligible for Free/Reduced Price Lunch

Data Background
The National Center for Education Statistics (NCES) is the primary federal entity for collecting, analyzing, and reporting data related to education in the United States and other nations. It fulfills a congressional mandate to collect, collate, analyze, and report full and complete statistics on the condition of education in the United States; conduct and publish reports and specialized analyses of the meaning and significance of such statistics; assist state and local education agencies in improving their statistical systems; and review and report on education activities in foreign countries.

Citation: Documentation to the NCES Common Core of Data Public Elementary/Secondary School Universe Survey (2011).

The National Center for Education Statistics releases a dataset containing detailed information about every public school in the United States in their annual Common Core of Data (CCD) files. The information from which this data is compiled is supplied by state education agency officials. The CCD reports information about both schools and school districts, including name, address, and phone number; descriptive information about students and staff demographics; and fiscal data, including revenues and current expenditures.

For more information, please visit the Common Core of Data web page.

Methodology
Total student counts and counts for students eligible for free and reduced price lunches are acquired for the school year 2009-2010 from the NCES Common Core of Data Public School Universe Survey. Percent student eligibility is calculated using the following formula:

\[
\text{Percentage} = \frac{\text{[Eligible Students]}}{\text{[Total Student Enrollment]}} \times 100.
\]

Point locations for schools are obtained by selecting the local address for each school in the public school universe file. Addresses are loaded into the Google Geocoding API service, which matches each record to a known address, and returns the corresponding point location coordinates.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Children in Poverty

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.
Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers’ dormitories) is many times more likely to be in poverty than people living in households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

High School Graduation Rate
Data Background
The National Center for Education Statistics (NCES) is the primary federal entity for collecting, analyzing, and reporting data related to education in the United States and other nations. It fulfills a congressional mandate to collect, collate, analyze, and report full and complete statistics on the condition of education in the United States; conduct and publish reports and specialized analyses of the meaning and significance of such statistics; assist state and local education agencies in improving their statistical systems; and review and report on education activities in foreign countries.

Citation: Documentation to the NCES Common Core of Data Public Elementary/Secondary School Universe Survey (2011).

The National Center for Education Statistics releases a dataset containing detailed information about every public school in the United States in their annual Common Core of Data (CCD) files. The information from which this data is compiled is supplied by state education agency officials. The CCD reports information about both schools and school districts, including name, address, and phone number; descriptive information about students and staff demographics; and fiscal data, including revenues and current expenditures.

For more information, please visit the Common Core of Data web page.

Methodology
Graduation rates are acquired for all US counties from the 2012 County Health Rankings (CHR). The 2011 County Health Rankings (CHR) used graduation rates calculated from the National Center for Education Statistics (NCES) using an estimated cohort. This measure is generally known as the Averaged Freshman Graduation Rate (AFGR). Starting in 2012, CHR reports cohort graduation rates collected from State Department of Education websites. These rates are an improvement over the AFGR rates previously reported due to student-level outcomes tracking that accounts
better for transfers, early and late completers. For 12 states, CHR continues to use NCES-based AFGRs. These states are: AL, AK, AR, CT, HI, ID, MT, NJ, ND, OK, SD and TN.

Total freshmen cohorts were compiled for all counties from school-level data, provided by NCES for academic years 2005-06 through 2007-08. Using the graduation rates from the 2012 CHR and these class sizes, the number of graduates* was estimated for each county. On-time graduation rate, or average freshman graduation rate, is re-calculated for unique service areas and aggregated county groupings using the following formula:

\[
\text{Graduation Rate} = \frac{\text{Estimated Number of Graduates}}{\text{Average Base Freshman Enrollment}} \times 100.
\]

*Average freshman graduation rate is a measure of on-time graduation only. It does not include 5th year high school completers, or high-school equivalency completers such as GED recipients. For more information on average freshman graduation rates, please review the information on page 4 of the NCES Common Core of Data Public-Use Local Education Agency Dropout and Completion Data File.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Income Over $75,000 (Family)
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.
Population in Poverty (100% FPL)

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \left( \frac{\text{Subgroup Population}}{\text{Total Population}} \right) \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers’ dormitories) is many times more likely to be in poverty than people living in households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

Population in Poverty (200% FPL)

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.
Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers’ dormitories) is many times more likely to be in poverty than people living in households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

Population Receiving Medicaid
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Methodology
Population counts for socio-economic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 3 year period 2009-2011. Data are summarized to 2010 Public Use Micro Area (PUMA) boundaries. Health insurance coverage status is classified in the ACS according to yes/no responses to questions (16a - 16h) representing eight categories of health insurance, including: Employer-based, Directly-purchased, Medicare, Medicaid/Medical Assistance, TRICARE, VA health care, Indian Health Service, and Other. An eligibility edit was applied to give Medicaid, Medicare, and TRICARE coverage to individuals based on program eligibility rules. People were considered insured if they reported at least one "yes" to Questions 16a - 16f. Indicator statistics are measured as a percentage of
the total population using the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2010 Subject Definitions.

**Data Limitations**
The population ‘universe’ for most health insurance coverage estimates is the civilian non-institutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Some non-institutionalized group quarters (GQ) populations have health insurance coverage distributions that are different from the household population (e.g., the prevalence of private health insurance among residents of college dormitories is higher than the household population). The proportion of the universe that is in the non-institutionalized GQ populations could therefore have a noticeable impact on estimates of the health insurance coverage. Institutionalized GQ populations may also have health insurance coverage distributions that are different from the civilian non-institutionalized population, the distributions in the published tables may differ slightly from how they would look if the total population were represented.

**Population with Associate's Level Degree or Higher**

**Data Background**
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

*Citation:* U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

**Methodology**
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.
Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations may have educational attainment distributions that are different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on the educational attainment distribution. This is particularly true for areas with a substantial GQ population.

Population with No High School Diploma

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

$$\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100$$

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations may have educational attainment distributions that are different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on the educational attainment distribution. This is particularly true for areas with a substantial GQ population.

Teen Births

Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health
**Methodology**

Counts for this indicator represent the annual average births over the 7-year period 2003-2009. Original data was tabulated by the CDC based on information reported on each birth certificate. Rates represent the number of births per 1,000 female population based on the following formula:

\[
\text{Rate} = \frac{\text{Births to Mothers Age 15-19}}{\text{Female Population Age 15-19}} \times 1,000
\]

Data was acquired from the Health Indicators Warehouse. For more information about this source, including data inclusion requirements and subject definitions, please visit the Health Indicator Warehouse indicator page or refer to the NVSS natality public use file documentation.

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

**Unemployment Rate**

**Data Background**

The Bureau of Labor Statistics (BLS) is the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy. Its mission is to collect, analyze, and disseminate essential economic information to support public and private decision-making. As an independent statistical agency, BLS serves its diverse user communities by providing products and services that are objective, timely, accurate, and relevant.

**Methodology**

Unemployment statistics are downloaded from the US Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics (LAUS) database. The LAUS is dataset consists of modeled unemployment estimates. It is described by the BLS as follows:

*The concepts and definitions underlying LAUS data come from the Current Population Survey (CPS), the household survey that is the official measure of the labor force for the nation. State monthly model estimates are controlled in "real time" to sum to national monthly labor force estimates from the CPS. These models combine current and historical data from the CPS, the Current Employment Statistics (CES) program, and State unemployment insurance (UI) systems. Estimates for seven large areas and their respective balances of State are also model-based. Estimates for the remainder of the substate labor market areas are produced through a building-block approach known as the "Handbook method." This procedure also uses data from several sources, including the CPS, the CES program, State UI systems, and the decennial census, to create estimates that are adjusted to the statewide measures of employment and unemployment. Below the labor market area level, estimates are prepared using disaggregation techniques based on inputs from the decennial census, annual population estimates, and current UI data.*

From the LAUS estimates, unemployment is recalculated as follows:
Unemployment Rate = \[\frac{\text{Total Unemployed}}{\text{Total Labor Force}} \times 100\]

For more information, please visit the Bureau of Labor Statistics [Local Area Unemployment Statistics](https://www.bls.gov) web page.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

**Uninsured Population (Adults)**

**Data Background**
The Small Area Health Insurance Estimates (SAHIE) program was created to develop model-based estimates of health insurance coverage for counties and states. It is currently the only dataset providing complete health-insurance coverage estimates at the county level. The models predict county level insurance estimates for total populations, as well as population groups defined by age, sex, race and income.

The SAHIE program models health insurance coverage by combining survey data with population estimates and administrative records. SAHIE estimates are a product of the US Census Bureau with funding from the Centers for Disease Control and Prevention.

The SAHIE health insurance models use data from the following sources:

- American Community Survey
- Internal Revenue Service: Federal Tax Returns
- Supplemental Nutrition Assistance Program (SNAP): Participation Records
- County Business Patterns
- Medicaid and Children’s Health Insurance Program (CHIP): Participation Records
- US Census 2010

**Methodology**
Counts of the number of persons without medical insurance are modeled for the Small Area Income and Health Insurance Estimates (SAHIE) datasets by the Census Bureau using both survey and census data. In this reporting platform, indicator percentages are summarized from the SAHIE estimates based on the following formula:

\[\text{Percentage} = \frac{\text{SUM [Uninsured Population]}}{\text{SUM [Total Population]}} \times 100\]

For more information about the data used in these estimates, please visit the Small Area Health Insurance Estimates website and view the provided Data Inputs page.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.
Uninsured Population (Children)

Data Background
The Small Area Health Insurance Estimates (SAHIE) program was created to develop model-based estimates of health insurance coverage for counties and states. It is currently the only dataset providing complete health-insurance coverage estimates at the county level. The models predict county level insurance estimates for total populations, as well as population groups defined by age, sex, race and income.

The SAHIE program models health insurance coverage by combining survey data with population estimates and administrative records. SAHIE estimates are a product of the US Census Bureau with funding from the Centers for Disease Control and Prevention.

The SAHIE health insurance models use data from the following sources:

- American Community Survey
- Internal Revenue Service: Federal Tax Returns
- Supplemental Nutrition Assistance Program (SNAP): Participation Records
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- Medicaid and Children’s Health Insurance Program (CHIP): Participation Records
- US Census 2010

Methodology
Counts of the number of persons without medical insurance are modeled for the Small Area Income and Health Insurance Estimates (SAHIE) datasets by the Census Bureau using both survey and census data. In this reporting platform, indicator percentages are summarized from the SAHIE estimates based on the following formula:

\[
\text{Percentage} = \frac{\text{SUM \ [Uninsured Population]}}{\text{SUM \ [Total Population]}} \times 100
\]

For more information about the data used in these estimates, please visit the Small Area Health Insurance Estimates website and view the provided Data Inputs page.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Uninsured Population (Total)

Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to
produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Population counts for socio-economic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 3 year period 2009-2011. Data are summarized to 2010 Public Use Micro Area (PUMA) boundaries. Health insurance coverage status is classified in the ACS according to yes/no responses to questions (16a - 16h) representing eight categories of health insurance, including: Employer-based, Directly-purchased, Medicare, Medicaid/Medical Assistance, TRICARE, VA health care, Indian Health Service, and Other. An eligibility edit was applied to give Medicaid, Medicare, and TRICARE coverage to individuals based on program eligibility rules. People were considered insured if they reported at least one "yes" to Questions 16a - 16f. Indicator statistics are measured as a percentage of the total population using the following formula:

$$\text{Percentage} = \frac{\text{Subgroup Population}}{\text{Total Population}} \times 100$$

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2010 Subject Definitions.

Data Limitations
The population ‘universe’ for most health insurance coverage estimates is the civilian non-institutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Some non-institutionalized group quarters (GQ) populations have health insurance coverage distributions that are different from the household population (e.g., the prevalence of private health insurance among residents of college dormitories is higher than the household population). The proportion of the universe that is in the non-institutionalized GQ populations could therefore have a noticeable impact on estimates of the health insurance coverage. Institutionalized GQ populations may also have health insurance coverage distributions that are different from the civilian non-institutionalized population, the distributions in the published tables may differ slightly from how they would look if the total population were represented.

Air Quality (Ozone)
Data Background
The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.

Methodology
Indicator data are acquired from the Centers for Disease Control and Prevention (CDC) and Environmental Protection Agency (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality Data web page. Utilized data includes the EPA’s daily Ozone concentration estimates, a Hierarchical Bayesian Space Time Modeling System (HBM) coverage for the contiguous U.S., presented as centroid-coordinates...
representing a 12 x 12 km grid. Data was extracted for each coordinate, including:

**Average Ozone Concentration** = \( \frac{\text{SUM} [\text{Concentration}]}{365} \)

**Number of Days Above Regulatory Standard** = \( \text{COUNT} [\text{Days Where Ozone} > 75] \)

Coordinates were converted to raster and all data was summarized by US census tracts (2010). Final data includes the average annual Ozone concentration, as well as the number and percentage of days where Ozone concentrations exceed air quality standards. For more information about the data used in these estimates, please visit the EPA's Air Quality Data resource page.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator.

### Air Quality (Particulate Matter 2.5)

**Data Background**
The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.

**Methodology**
Indicator data are acquired from the Centers for Disease Control and Prevention (CDC) and Environmental Protection Agency (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality Data web page. Utilized data includes the EPA’s daily Ozone concentration estimates, a Hierarchical Bayesian Space Time Modeling System (HBM) coverage for the contiguous U.S., presented as centroid-coordinates representing a 12 x 12 km grid. Data was extracted for each coordinate, including:

**Average Ozone Concentration** = \( \frac{\text{SUM} [\text{Concentration}]}{365} \)

**Number of Days Above Regulatory Standard** = \( \text{COUNT} [\text{Days Where Ozone} > 75] \)

Coordinates were converted to raster and all data was summarized by US census tracts (2010). Final data includes the average annual Ozone concentration, as well as the number and percentage of days where Ozone concentrations exceed air quality standards. For more information about the data used in these estimates, please visit the EPA's Air Quality Data resource page.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator.

### Fast Food Restaurant Access

**Data Background**
County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.
Country Business Patterns basic data items are extracted from the Business Register (BR), a database of all known single and multi-establishment employer companies maintained and updated by the U.S. Census Bureau. The BR contains the most complete, current, and consistent data for business establishments. The annual Company Organization Survey provides individual establishment data for multi-establishment companies. Data for single-establishment companies are obtained from various Census Bureau programs, such as the Economic Census, Annual Survey of Manufactures and Current Business Surveys, as well as from administrative record sources.

Citation: U.S. Census Bureau: County Business Patterns (2012).
For more information about this source, including data collection methodology and definitions, refer to the County Business Patterns.

Methodology
Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry Classification System (NAICS) a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{\text{[Establishment Count]}}{\text{[Population]}} \times 100,000
\]

The specific codes used indicators reported from the Census Bureau's County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  *Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.*

- Fast food restaurants: 722211
  *Any “limited service” establishments where the customer typically orders or selects items and pays before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants.*

- Alcoholic beverage retailers: 445310
  *Establishments engaged in "retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor". Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.*

- Recreational Facilities: 713940
  *Establishments engaged in operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities”. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

A complete list of NAICS codes and definitions is available using the NAICS Association’s free lookup service.
Data Limitations
1. Data are reported based on the primary NAICS code of the establishment. By definition, the primary NAICS code should reflect 50% or more of the establishment’s activity. This definition may exclude some establishments from a particular industry classification. For example, a convenience store which also sells liquor may be classified only as a convenience store (445120) and not a beer, wine and liquor store (445310).

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Grocery Store Access
Data Background
County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.

County Business Patterns basic data items are extracted from the Business Register (BR), a database of all known single and multi-establishment employer companies maintained and updated by the U.S. Census Bureau. The BR contains the most complete, current, and consistent data for business establishments. The annual Company Organization Survey provides individual establishment data for multi-establishment companies. Data for single-establishment companies are obtained from various Census Bureau programs, such as the Economic Census, Annual Survey of Manufactures and Current Business Surveys, as well as from administrative record sources.

Citation: U.S. Census Bureau: County Business Patterns (2012).
For more information about this source, including data collection methodology and definitions, refer to the County Business Patterns

Methodology
Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry Classification System (NAICS) a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{\text{Establishment Count}}{\text{Population}} \times 100,000
\]

The specific codes used indicators reported from the Census Bureau’s County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are
excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.

- **Fast food restaurants:** 722211
  
  *Any “limited service” establishments where the customer typically orders or selects items and pay before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants*

- **Alcoholic beverage retailers:** 445310
  
  *Establishments engaged in “retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor“. Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.*

- **Recreational Facilities:** 713940
  
  *Establishments engaged in operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities”. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

A complete list of NAICS codes and definitions is available using the NAICS Association’s [free lookup service](#).

**Data Limitations**

1. Data are reported based on the primary NAICS code of the establishment. By definition, the primary NAICS code should reflect 50% or more of the establishment’s activity. This definition may exclude some establishments from a particular industry classification. For example, a convenience store which also sells liquor may be classified only as a convenience store (445120) and not a beer, wine and liquor store (445310).

**Race and Ethnicity**

Statistics by race and ethnicity are not provided for this indicator.

**Liquor Store Access**

**Data Background**

County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.

County Business Patterns basic data items are extracted from the Business Register (BR), a database of all known single and multi-establishment employer companies maintained and updated by the U.S. Census Bureau. The BR contains the most complete, current, and consistent data for business establishments. The annual Company Organization Survey provides individual establishment data for multi-establishment companies. Data for single-establishment companies are obtained from various Census Bureau programs, such as the Economic Census, Annual Survey of Manufacures and Current Business Surveys, as well as from administrative record sources.

**Citation:** [U.S. Census Bureau: County Business Patterns (2012)](#)

For more information about this source, including data collection methodology and definitions, refer to the [County Business Patterns](#)
Methodology
Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry Classification System (NAICS), a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{[\text{Establishment Count}]}{[\text{Population}]} \times 100,000
\]

The specific codes used to indicate reported from the Census Bureau's County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  *Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.*

- Fast food restaurants: 722211
  *Any “limited service” establishments where the customer typically orders or selects items and pay before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants.*

- Alcoholic beverage retailers: 445310
  *Establishments engaged in “retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor“. Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.*

- Recreational Facilities: 713940
  *Establishments engaged in “operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

A complete list of NAICS codes and definitions is available using the NAICS Association’s [free lookup service](#).

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Data Limitations
1. Data are reported based on the primary NAICS code of the establishment. By definition, the primary NAICS code should reflect 50% or more of the establishment’s activity. This definition may exclude some establishments from a particular industry classification. For example, a convenience store which also sells liquor may be classified only as a convenience store (445120) and not a beer, wine and liquor store (445310).
2. State laws regarding the retail sale of alcoholic beverages vary. Use caution when comparing data across States.

Low Income Population with Low Food Access
Data Background
The Food Access Research Atlas (FARA) presents a spatial overview of food access indicators for populations using different measures of supermarket accessibility. The FARA is a compliment to the USDA’s Food Environment Atlas, which houses county-level food related data. The FARA provides census-tract level detail of the food access measures, including food desert census tracts. Estimates in the Food Access Research Atlas draw from various sources, including the 2010 STARS list of supermarkets, the Supplemental Nutrition Assistance Program (SNAP) Retailer Directory, the 2010 Decennial Census, and the 2006-10 American Community Survey.

For more information about this source, including the methodology and data definitions please visit the Food Access Research Atlas web page.

Methodology
Census tract-level data was acquired from the USDA Food Access Research Atlas (FARA) and aggregated to generate county and state-level estimates.

The FARA hosts data derived through the analysis of multiple sources. First, a directory of supermarkets and large grocery stores within the United States, including Alaska and Hawaii, was derived from merging the 2010 STARS directory of stores authorized to accept SNAP benefits and the 2010 Trade Dimensions TDLinx directory of stores. Stores met the definition of a supermarket or large grocery store if they reported at least $2 million in annual sales and contained all the major food departments found in a traditional supermarket, including fresh meat and poultry, dairy, dry and packaged foods, and frozen foods. The combined list of supermarkets and large grocery stores was converted into a GIS-readable format by geocoding the street address into store-point locations. Population data are reported at the block level from the 2010 Census of Population and Housing, while data on income are drawn at the block group-level from the 2006-10 American Community Survey. Distance to nearest supermarket was determined for population blocks. Blocks were determined to be "low-access" based on the distance of the block centroid to the nearest grocery store. For blocks within urban census tracts, the low-access cut off was 1 mile; for blocks within rural census tracts, the cut off was 10 miles. Rural or urban status is designated by the Census Bureau’s Urban Area definition. Low-income is defined as annual family income of less than or equal to 200 percent of the Federal poverty threshold given family size.

For more information, please refer to the Food Access Research Atlas Documentation.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Park Access
Data Background
The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.

Population with Low Food Access
Data Background
The Food Access Research Atlas (FARA) presents a spatial overview of food access indicators for populations using different measures of supermarket accessibility. The FARA is a compliment to the USDA’s Food Environment Atlas, which houses county-level food related data. The FARA provides census-tract level detail of the food access measures, including food desert census tracts. Estimates in the Food Access Research Atlas draw from various sources, including the 2010 STARS list of supermarkets, the Supplemental Nutrition Assistance Program (SNAP) Retailer Directory, the 2010 Decennial Census, and the 2006-10 American Community Survey.

For more information about this source, including the methodology and data definitions please visit the Food Access Research Atlas web page.

Methodology
Census tract-level data was acquired from the USDA Food Access Research Atlas (FARA) and aggregated to generate county and state-level estimates.

The FARA hosts data derived through the analysis of multiple sources. First, a directory of supermarkets and large grocery stores within the United States, including Alaska and Hawaii, was derived from merging the 2010 STARS directory of stores authorized to accept SNAP benefits and the 2010 Trade Dimensions TDLinx directory of stores. Stores met the definition of a supermarket or large grocery store if they reported at least $2 million in annual sales and contained all the major food departments found in a traditional supermarket, including fresh meat and poultry, dairy, dry and packaged foods, and frozen foods. The combined list of supermarkets and large grocery stores was converted into a GIS usable format by geocoding the street address into store-point locations. Population data are reported at the block level from the 2010 Census of Population and Housing, while data on income are drawn at the block group-level from the 2006-10 American Community Survey. Distance to nearest supermarket was determined for population blocks. Blocks were determined to be "low-access" based on the distance of the block centroid to the nearest grocery store. For blocks within urban census tracts, the low-access cut off was 1 mile; for blocks within rural census tracts, the cut off was 10 miles. Rural or urban status is designated by the Census Bureau’s Urban Area definition. Low-income is defined as annual family income of less than or equal to 200 percent of the Federal poverty threshold given family size.

For more information, please refer to the Food Access Research Atlas Documentation.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Recreation and Fitness Facility Access

Data Background
County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.
County Business Patterns basic data items are extracted from the Business Register (BR), a database of all known single and multi-establishment employer companies maintained and updated by the U.S. Census Bureau. The BR contains the most complete, current, and consistent data for business establishments. The annual Company Organization Survey provides individual establishment data for multi-establishment companies. Data for single-establishment companies are obtained from various Census Bureau programs, such as the Economic Census, Annual Survey of Manufactures and Current Business Surveys, as well as from administrative record sources.

**Citation:** *U.S. Census Bureau: County Business Patterns (2012)*. For more information about this source, including data collection methodology and definitions, refer to the County Business Patterns Methodology.

**Methodology**

Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry Classification System (NAICS) a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{\text{Establishment Count}}{\text{Population}} \times 100,000
\]

The specific codes used indicators reported from the Census Bureau's County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  *Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.*

- Fast food restaurants: 722211
  *Any “limited service” establishments where the customer typically orders or selects items and pay before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants.*

- Alcoholic beverage retailers: 445310
  *Establishments engaged in “retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor“. Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.*

- Recreational Facilities: 713940
  *Establishments engaged in operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities”. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.*

A complete list of NAICS codes and definitions is available using the NAICS Association’s free lookup service.
Data Limitations
1. Data are reported based on the primary NAICS code of the establishment. By definition, the primary NAICS code should reflect 50% or more of the establishment’s activity. This definition may exclude some establishments from a particular industry classification. For example, a convenience store which also sells liquor may be classified only as a convenience store (445120) and not a beer, wine and liquor store (445310).

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

SNAP-Authorized Food Store Access
Data Background
The Food Environment Atlas provides access to the majority of the food-related datasets of the U.S. Department of Agriculture (USDA) Economic Research Service (ERS). The ERS performs research about food security in U.S. households and communities, and provides data access to national, state, and local statistics from its analysis. The ERS draws from various sources to measure population food security, including internal USDA databases (the Supplemental Nutrition Assistance Program (SNAP) Retailer Directory, the National Farmers Market Directory, the Census of Agriculture, the Quarterly Food-At-Home Price Database) and data from other federal programs like the Decennial Census and the Behavioral Risk Factor Surveillance System.

For more information about this source, please visit the Food Environment Atlas.

Methodology
County-level data was acquired from the USDA Food Environmental Atlas (FEA).

The FEA reports SNAP-Authorized retailers as a rate per 1,000 population. The FEA acquires store data are from USDA's Food and Nutrition Service, SNAP Benefits Redemption Division. The FEA acquires population data from the U.S. Census Bureau program. This CHNA indicator is represented as a rate per 100,000 population based on the following formula:

\[
\text{Rate} = \frac{\text{[SNAP-Authorized Retailers]}}{\text{[Total Population]}} \times 100,000
\]

For more information, please refer to the Food Environmental Atlas Documentation.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Use of Public Transportation
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to
produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: *U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).*
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

**Methodology**

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2007-2011. Data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population using the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

For more information on the specific data elements reported in the American Community Survey, please see the complete American Community Survey 2011 Subject Definitions.

**Notes**

**WIC-Authorized Food Store Access**

**Data Background**

The Food Environment Atlas provides access to the majority of the food-related datasets of the U.S. Department of Agriculture (USDA) Economic Research Service (ERS). The ERS performs research about food security in U.S. households and communities, and provides data access to national, state, and local statistics from its analysis. The ERS draws from various sources to measure population food security, including internal USDA databases (the Supplemental Nutrition Assistance Program (SNAP) Retailer Directory, the National Farmers Market Directory, the Census of Agriculture, the Quarterly Food-At-Home Price Database) and data from other federal programs like the Decennial Census and the Behavioral Risk Factor Surveillance System.

For more information about this source, please visit the Food Environment Atlas.

**Methodology**

County-level data was acquired from the USDA Food Environmental Atlas (FEA).

The FEA reports WIC-Authorized retailers as a rate per 1,000 population. The FEA reports WIC-store data from USDA’s Food and Nutrition Service, Supplemental Food Programs Division, Program Analysis and Monitoring Branch. Population data are from the U.S. Census Bureau Population Estimates. WIC-store access rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{\text{[Establishment Count]}}{\text{[Population]}} \times 100,000
\]
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Access to Primary Care
Data Background
The Area Resource File (ARF) is a database of information about the U.S. health care system, maintained and released annually by the U.S. Health and Human Services (HHS) Health Resources and Services Administration (HRSA). The ARF contains more than 6,000 variables, aggregated for each of the nation's counties. The ARF contains information on health facilities, health professions, health status, economic activity, health training programs, measures of resource scarcity, and socioeconomic and environmental characteristics. In addition, the basic file contains geographic codes and descriptors which enable it to be linked to many other files and to aggregate counties into various geographic groupings.

The ARF integrates data from numerous primary data sources including: the American Hospital Association, the American Medical Association, the American Dental Association, the American Osteopathic Association, the Bureau of the Census, the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), Bureau of Labor Statistics, National Center for Health Statistics and the Veteran’s Administration.

For more information, please visit HRSA’s Area Resource File website.

Methodology
Counts of primary care providers are acquired from the Health Resources and Services Administration (HRSA) 2011 Area Resource File, and population data from the U.S. Census Bureau 2010 decennial census. Primary care provider rates are then calculated using the following formula:

\[
\text{Provider Rate} = \left( \frac{\text{Number of Primary Care Physicians}}{\text{Total Population}} \right) \times 100,000
\]

For more information and to view the original data used for this calculation, please visit the HRSA Area Resource File website.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Breast Cancer Screening (Mammogram)
Data Background
The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.
Methodology
The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data tables express the proportion of Medicare Part B patients screened for medical conditions based on the following formula:

\[ \text{Percentage} = \frac{\text{Number Screened}}{\text{Total Patients}} \times 100 \]

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex. Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.

Cervical Cancer Screening (Pap Test)

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2004-2010 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following questions:

"A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?"

Respondents are considered to have had a Pap test if they answer that they had ever had a test. Percentages are age-adjusted and only pertain to the non-institutionalized female population aged 18 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[ \text{Persons having a Pap test} = \left( \frac{\text{Indicator Percentage}}{100} \right) \times \text{Total Population} \]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.
Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Colon Cancer Screening (Sigmoid/Colonoscopy)

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. ”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2004-2010 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following questions:

"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams? For a SIGMOIDOSCOPY, a flexible tube is inserted into the rectum to look for problems. A COLONOSCOPY is similar but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. Was your MOST RECENT exam a sigmoidoscopy or a colonoscopy? How long has it been since you had your last sigmoidoscopy or colonoscopy?"
Respondents are considered to have had a Sigmoidoscopy/Colonoscopy if they answer that they had ever had a test. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 50 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
[\text{Persons having a Sigmoidoscopy/Colonoscopy}] = \left(\frac{[\text{Indicator Percentage}]}{100}\right) \times [\text{Total Population}].
\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

**Data Suppression**
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

**Dental Care Utilization (Adult)**

**Data Background**
The Behavioral Risk Factor Surveillance System (BRFSS) is “...a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. *Overview: BRFSS 2010.*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS *Annual Survey Data* web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

**Methodology**
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

> "How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.” and “How long has it been since you had your teeth cleaned by a dentist or dental hygienist?” This indicator represents the percentage
of respondents who indicated that they had not seen any dentist or dental hygienist within the past year. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

\[ \text{Adults Without Recent Dental Exam} = \left( \frac{\text{Indicator Percentage}}{100} \right) \times \text{[Total Population]} . \]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

**Diabetes Management (Hemoglobin A1c Test)**

**Data Background**

The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the [Dartmouth Atlas of Healthcare](https://www.dartmouthatlas.org) website.

**Methodology**

The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data tables express the proportion of Medicare Part B patients screened for medical conditions based on the following formula:

\[ \text{Percentage} = \frac{\text{[Number Screened]}}{\text{[Total Patients]}} \times 100 \]

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.
Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.

Facilities Designated as Health Professional Shortage Areas

Data Background
Health Professional Shortage Areas (HPSAs) are designated by the US Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers. HPSAs may refer to an entire geographic area (a county or service area), a demographic group within a geographic area (low income population) or an institution (comprehensive health center, federally qualified health center or other public facility).

HPSAs are designated using several criteria, depending on the type of designation. For example, a HPSA may be designated on the basis that medical professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to the population under consideration. HPSAs are also designated based on population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care. All Federally Qualified Health Centers and Rural Health Clinics that provide access to care, regardless of patient ability to pay, receive automatic facility HPSA designation.

HPSAs are updated on a continuous basis through the US Health and Humans Services (HHS) Health Resources and Services Administration (HRSA) GIS data warehouse. For more information about HPSAs, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

Methodology
Health Professional Shortage Area (HPSA) facility files were acquired from the US Health Resources and Services Administration (HRSA) GIS data warehouse. The point locations of these institutions, along with their designation type, were intersected with geographic areas to provide a count of the total number of facilities in an area.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Federally Qualified Health Centers

Data Background
Providers of Service (POS) data is compiled quarterly by Research and Planning Consultants, LP (RPC) for the Centers for Medicare and Medicaid Services (CMS). The Provider of Services (POS) Extract is created from the QIES (Quality Improvement Evaluation System) database. These data include provider number, name, and address and characterize the participating institutional providers. The data are collected through the Centers for Medicare & Medicaid Services (CMS) Regional Offices. The file contains an individual record for each Medicare-approved provider and is updated quarterly.

Methodology
Addresses for all active federally qualified health centers (FQHCs) were acquired from the Centers for Medicare and Medicaid Services (CMS) Providers of Service (POS) data file. FQHC addresses were geocoded using the Google Geocoding API to obtain the coordinates (point-location) of each facility. The resulting point location file was intersected with standard geographic areas (tracts, counties, and states) to generate a count of the total FQHCs in each area.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator.

**High Blood Pressure Management**

**Data Background**
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

**Methodology**
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"*Have you EVER been told by a doctor, nurse or other health professional that you have high blood pressure?*” and “*Are you currently taking medicine for your high blood pressure?*”

This indicator represents the percentage of those persons who answered that ‘yes’ they have high blood pressure who also answered ‘no’, that they are not currently taking medication to control it. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

**Adults Not Taking Blood Pressure Medication = ([Indicator Percentage] / 100) * [Total Adult Population]**

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.
Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

HIV Screenings
Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”
Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following question:

"Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth."

This indicator represents the percentage of those persons who answered “no”, indicating that they have never been tested for HIV/AIDS. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:
Adults Never Tested for HIV/AIDS = ([Indicator Percentage] / 100) * [Total Adult Population]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

Lack of a Consistent Source of Primary Care

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"Do you have one person you think of as your personal doctor or health care provider? (If "No" ask "Is there more than one or is there no
person who you think of as your personal doctor or health care provider?"

This indicator represents the percentage of those persons who answered “no” to both parts of the question, indicating that they do not see any regular doctor. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

\[ \text{Adults Without Any Regular Doctor} = \left( \frac{\text{Indicator Percentage}}{100} \right) \times \text{[Total Adult Population]} \]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

Pneumonia Vaccinations (Age 65 )
Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.
For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following questions:

"Have you EVER had a pneumonia shot? A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime and is different from the flu shot. Have you ever had a pneumonia shot?"

Respondents are considered to have had a pneumonia vaccination if they answer that they had ever had a vaccine. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 65 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
\text{[Persons having a Pneumonia vaccination]} = \left(\frac{\text{[Indicator Percentage]}}{100}\right) \times \text{[Total Population]}.\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Population Living in a Health Professional Shortage Area
Data Background
Health Professional Shortage Areas (HPSAs) are designated by the US Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers. HPSAs may refer to an entire geographic area (a county or service area), a demographic group within a geographic area (low income population) or an institution (comprehensive health center, federally qualified health center or other public facility).

HPSAs are designated using several criteria, depending on the type of designation. For example, a HPSA may be designated on the basis that medical professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to the population under consideration. HPSAs are also designated based on population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care. All Federally Qualified Health Centers and Rural Health Clinics that provide access to care, regardless of patient ability to
pay, receive automatic facility HPSA designation.

HPSAs are updated on a continuous basis through the US Health and Humans Services (HHS) Health Resources and Services Administration (HRSA) GIS data warehouse. For more information about HPSAs, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

**Methodology**
Health Professional Shortage Area (HPSA) boundary files were acquired from the US Health Resources and Services Administration (HRSA) GIS data warehouse. Data from HRSA contained estimates of the total designation population, and the population underserved in each service area. Total designation populations vary based on HPSA designation, and may refer to the total area population, or the population of a specific demographic (income, racial, ethnic) group. Population figures provided by HRSA represent the estimate at the time of last designation update, which in some cases is as early as 2008. The percentage of population underserved is based on the following formula:

\[
\text{Percentage} = \frac{\text{Underserved Population}}{\text{Total Designation Population}} \times 100
\]

For additional information, including designation procedures and access to the original data, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

**Preventable Hospital Events**

**Data Background**
The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

**Methodology**
The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data tables express the rate of Medicare Part A patients discharged from the hospital for preventable / ambulatory care sensitive (ACS) conditions like asthma, diabetes, pneumonia, or COPD, based on the following formula:

\[
\text{Rate} = \frac{\text{ACS Condition Discharges}}{\text{Total Patients}} \times 10,000
\]

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.

Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.
Alcohol Consumption

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following question:

"One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?"

Respondents are considered heavy drinkers if they were male and reported having more than 2 drinks per day, or females that reported having more than 1 drink per day. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
[\text{Heavy Drinkers}] = \left( \frac{[\text{Indicator Percentage}]}{100} \right) \times [\text{Total Population}].
\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each
geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

**Alcohol Expenditures**

**Data Background**

Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, Site Reports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The Site Reports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics' Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade

For more information, please visit the [Nielsen Site Reports](#) website.

**Methodology**

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) Site Reports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{[Category Expenditures]}}{\text{[Total Area Expenditures]}} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- **Soft drinks**: *Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.*
- **Alcoholic beverages**: *Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.*
- **Fruit and vegetables:** *Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.*
- **Tobacco:** *Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.*

Further details about the analysis used by Nielsen group can be found in the [Consumer Buying Power Methodology](#).

**Race and Ethnicity**

Statistics by race and ethnicity are not provided for this indicator.

**Fruit/Vegetable Consumption**

**Data Background**

The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. [Overview: BRFSS 2010](#).*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the [Health Indicator Warehouse](#), the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the [Behavioral Risk Factor Surveillance System](#) home page.

**Methodology**

Indicator percentages are acquired for years 2005-2009 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Data are based on the percentage of respondents who report regularly consuming five or more servings of fruits or vegetables each week. Fried potatoes and chips are excluded. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults consuming 5 servings) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
\text{[Population Consuming 5 Servings]} = \left(\frac{\text{[Indicator Percentage]}}{100}\right) \times \text{[Total Population]}
\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and [data processing methodologies](#) are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the [Health Indicator Warehouse](#).
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Fruit/Vegetable Expenditures
Data Background
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, Site Reports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The Site Reports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics' Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade

For more information, please visit the Nielsen Site Reports website.

Methodology
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) Site Reports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{Category Expenditures}}{\text{Total Area Expenditures}} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the
map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- **Soft drinks:** *Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.*
- **Alcoholic beverages:** *Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.*
- **Fruit and vegetables:** *Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.*
- **Tobacco:** *Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.*

Further details about the analysis used by Nielsen group can be found in the [Consumer Buying Power Methodology](#).

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator.

**Physical Inactivity (Adult)**

**Data Background**
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publically available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

*Citation:* [Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012)].

**Methodology**
Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention’s National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

\[
\text{Percent Prevalence} = \left( \frac{\text{Risk Factor Population}}{\text{Total Population}} \right) \times 100.
\]

All data are estimates modeled by the CDC using the methods described below:
The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC’s [Behavioral Risk Factor Surveillance System (BRFSS)](https://www.cdc.gov/brfss/) and data from the [U.S. Census Bureau’s Population Estimates Program](https://www.census.gov/programs-surveys/estimates.html). The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state-specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-
report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that “borrows strength” in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65 + race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention. Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Rates were age adjusted by the CDC for the following three age groups: 20–44, 45–64, 65+. Additional information, including the complete methodology and data definitions, can be found at the CDC’s Diabetes Data and Trends website.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Soda Expenditures
Data Background
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, Site Reports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The Site Reports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics’ Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade
Methodology
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) Site Reports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{[\text{Category Expenditures}]}{[\text{Total Area Expenditures}]} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- Soft drinks: Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.
- Alcoholic beverages: Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.
- Fruit and vegetables: Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.
- Tobacco: Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.

Further details about the analysis used by Nielsen group can be found in the Consumer Buying Power Methodology.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Tobacco Expenditures
Data Background
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, Site Reports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The Site Reports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics’ Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen
Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade

For more information, please visit the Nielsen Site Reports website.

Methodology
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) Site Reports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{Category Expenditures}}{\text{Total Area Expenditures}} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- Soft drinks: *Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.*
- Alcoholic beverages: *Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.*
- Fruit and vegetables: *Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.*
- Tobacco: *Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.*

Further details about the analysis used by Nielsen group can be found in the Consumer Buying Power Methodology.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Tobacco Usage (Current Smokers)
Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors
for the adult population (18 years of age or older) living in households. ”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Data are based on the percentage of respondents answering the following question:

"Do you now smoke cigarettes every day, some days, or not at all?"

Respondents are considered smokers if they reported smoking every day or some days. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adult smokers) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[ \text{[Adults Smokers]} = (\text{[Indicator Percentage]} / 100) \times \text{[Total Population]} \]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Tobacco Usage (Former or Current Smokers)

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is
“... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. *Overview: BRFSS 2010.*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

**Methodology**

Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"Do you have one person you think of as your personal doctor or health care provider? (If "No" ask "Is there more than one or is there no person who you think of as your personal doctor or health care provider?")."

This indicator represents the percentage of those persons who answered “no” to both parts of the question, indicating that they do not see any regular doctor. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

**Adults Without Any Regular Doctor = ([Indicator Percentage] / 100) * [Total Adult Population]**

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White,
Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

**Tobacco Usage (Quit Attempt)**

**Data Background**

The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the [Behavioral Risk Factor Surveillance System](https://www.cdc.gov/brfss) home page.

**Methodology**

Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"Do you have one person you think of as your personal doctor or health care provider? (If "No" ask "Is there more than one or is there no person who you think of as your personal doctor or health care provider?")."

This indicator represents the percentage of those persons who answered “no” to both parts of the question, indicating that they do not see any regular doctor. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

**Adults Without Any Regular Doctor = ([Indicator Percentage] / 100) * [Total Adult Population]**

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.
**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

**Accident Mortality**

**Data Background**

The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

**Methodology**

County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times \left(\frac{\text{Age-Adjusted Rate}}{100,000}\right)}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Asthma Prevalence
Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"Have you ever been told by a doctor, nurse, or health professional that you have Asthma?"

This indicator represents the percentage of those persons who answered “yes”. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

Adults Diagnosed with Asthma = ([Indicator Percentage] / 100) * [Total Population].

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.
Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

**Data Suppression**
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

**Race and Ethnicity**
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

**Breast Cancer Incidence**

**Data Background**
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

**Methodology**
Annual incidence rates are acquired for all US states and counties as an average for years 2005-2009 from the State Cancer Profiles: Incidence Rates data tables. Incidence rates provided from this source are age adjusted to the 2000 US standard population. In order to perform aggregate (multi-county or service area) estimates with the data provided, adjusted cancer incidence rates are back-calculated using the following formula:

\[
\text{SUM}([\text{Age-Adjusted Rate}/100,000] \times \text{SUM}[\text{Total Population}]) / \text{SUM}[\text{Total Population}] \times 100,000.
\]

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community
Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state cancer registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic), and for the white Hispanic and white non-Hispanic population.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored. In addition, because of the impact on Louisiana's population in 2005 due to Hurricanes Katrina/Rita, the cases diagnosed in Louisiana during that period (July - December 2005) are excluded. The count has been suppressed due to data consistency issues.

Cancer Mortality
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times ((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.
- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86

**Race and Ethnicity**
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

**Data Suppression**
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

**Cervical Cancer Incidence**

**Data Background**
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles website provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

**Methodology**
Annual incidence rates are acquired for all US states and counties as an average for years 2005-2009 from the State Cancer Profiles: Incidence Rates data tables. Incidence rates provided from this source are age adjusted to the 2000 US standard population. In order to perform aggregate (multi-
county or service area) estimates with the data provided, adjusted cancer incidence rates are back-calculated using the following formula:

\[
\text{SUM}([\text{Age-Adjusted Rate}/100,000] \times \text{SUM}[\text{Total Population}]) / \text{SUM}[\text{Total Population}] \times 100,000.
\]

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories by state cancer registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic), and for the white Hispanic and white non-Hispanic population.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored. In addition, because of the impact on Louisiana's population in 2005 due to Hurricanes Katrina/Rita, the cases diagnosed in Louisiana during that period (July - December 2005) are excluded. The count has been suppressed due to data consistency issues.

**Chlamydia Incidence**

**Data Background**

The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTEP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

**Methodology**

Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number
of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

For more information, visit the NCHHSTP Atlas and click on the “About these data and footnotes” link.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Colon and Rectum Cancer Incidence
Data Background
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

Methodology
Annual incidence rates are acquired for all US states and counties as an average for years 2005-2009 from the State Cancer Profiles: Incidence Rates data tables. Incidence rates provided from this source are age adjusted to the 2000 US standard population. In order to perform aggregate (multi-county or service area) estimates with the data provided, adjusted cancer incidence rates are back-calculated using the following formula:

\[
\text{SUM}([\text{Age-Adjusted Rate}/100,000] \times \text{SUM}[\text{Total Population}]) / \text{SUM}[\text{Total Population}] \times 100,000.
\]

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state cancer registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic), and for the white Hispanic and white non-Hispanic population.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored. In addition, because of the impact on Louisiana's population in 2005 due to Hurricanes Katrina/Rita, the cases diagnosed in Louisiana during that period (July - December 2005) are excluded. The count has been suppressed due to data consistency issues.

**Diabetes Prevalence**

**Data Background**

The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publicly available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.


**Methodology**

Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabets, a service of the Centers for Disease Control and Prevention’s National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

\[
\text{Percent Prevalence} = \frac{[\text{Risk Factor Population}]}{[\text{Total Population}]} \times 100.
\]

All data are estimates modeled by the CDC using the methods described below:

The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC’s Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau’s Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state-specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]^2) was derived from self-report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race,
and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that “borrows strength” in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65 ; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention. Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Rates were age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65. Additional information, including the complete methodology and data definitions, can be found at the CDC’s Diabetes Data and Trends website.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Gonorrhea Incidence
Data Background
The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

Methodology
Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

For more information, visit the NCHHSTP Atlas and click on the “About these data and footnotes” link.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Heart Disease Mortality
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events — births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times ((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.
Heart Disease Prevalence

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"Has a doctor, nurse, or other health professional ever told you that you had any of the following:
- Ever told you had a heart attack, also called myocardial infarction?
- Ever told you had angina or coronary heart disease?
- Ever told you had a stroke?"

This indicator represents the percentage of those persons who answered that “yes”, they have been diagnosed with angina or coronary heart disease. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

\[
\text{Adults Diagnosed with Heart Disease} = \left(\frac{\text{Indicator Percentage}}{100}\right) \times \text{[Total Population]}.
\]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

HIV Prevalence
Data Background
The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

Methodology
Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

For more information, visit the NCHHSTP Atlas and click on the “About these data and footnotes” link.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Homicide
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages,
divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population) * ((Age-Adjusted Rate)/100,000)}}{\text{SUM(Total Population)}} \times 100,000
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Infant Mortality
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
Counts for this indicator represent the annual average births and deaths over the 7-year period 2003-2009. Original data was tabulated by the CDC based on information reported on birth and death certificates. Rates represent the number of deaths to infants under age 1 per 1,000 total live births, based on the following formula:

\[
\text{Rate} = \frac{\text{Total Deaths Under Age 1}}{\text{Total Births}} \times 1,000
\]

Data are not linked (birth and death certificates have not been matched) and thus this indicator does not account for population migration. Mortality data was acquired from the CDC WONDER query system. Birth tabulations were acquired from the Health Indicators Warehouse. For more information, about these sources, including data inclusion requirements and subject definitions, please visit the Health Indicator Warehouse indicator page or refer to the CDC WONDER Underlying Cause of Death documentation.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Low Birth Weight
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
Counts for this indicator represent the annual average births over the 7-year period 2003-2009. Original data was tabulated by the CDC based on information reported on each birth certificate. Rates represent the number of births weighing less than 2,500 grams per 100 live births based on the following formula:

\[
\text{Rate} = \frac{\text{Births Weighting < 2500g}}{\text{Total Births}} \times 100
\]
Data was acquired from the Health Indicators Warehouse. For more information about this source, including data inclusion requirements and subject definitions, please visit the Health Indicator Warehouse indicator page or refer to the NVSS natality public use file documentation.

**Race and Ethnicity**
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

**Lung Cancer Incidence**

**Data Background**
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

**Methodology**
Annual incidence rates are acquired for all US states and counties as an average for years 2005-2009 from the State Cancer Profiles: Incidence Rates data tables. Incidence rates provided from this source are age adjusted to the 2000 US standard population. In order to perform aggregate (multi-county or service area) estimates with the data provided, adjusted cancer incidence rates are back-calculated using the following formula:

\[
\text{SUM}([\text{Age-Adjusted Rate}/100,000] * \text{SUM}[\text{Total Population}]) / \text{SUM}[\text{Total Population}] * 100,000.
\]

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.
**Race and Ethnicity**
Race and ethnicity (Hispanic origin) are collected as two separate categories by state cancer registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic), and for the white Hispanic and white non-Hispanic population.

**Data Suppression**
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored. In addition, because of the impact on Louisiana's population in 2005 due to Hurricanes Katrina/Rita, the cases diagnosed in Louisiana during that period (July - December 2005) are excluded. The count has been suppressed due to data consistency issues.

**Lung Disease Mortality**

**Data Background**
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

**Methodology**
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times ((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
• Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Motor Vehicle Crash Death
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events—births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times \left(\frac{\text{Age-Adjusted Rate}}{100,000}\right)}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

• Assault (homicide): U01-U02, X85-Y09, Y87.1
• Cerebrovascular disease (stroke): I60-I69
• Coronary heart disease: I11, I20-I25
• Chronic lower respiratory disease: J40-J47
Intentional self-harm (suicide): X60-X84, Y870
Malignant neoplasm (cancer): C00-C97
Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Obesity (Adult)
Data Background
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publicly available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Methodology
Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention’s National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:


All data are estimates modeled by the CDC using the methods described below:
The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC’s Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau’s Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state-specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]^2) was derived from self-
report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that “borrows strength” in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65+; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Rates were age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65+. Additional information, including the complete methodology and data definitions, can be found at the CDC’s Diabetes Data and Trends website.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Overweight (Adult)

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

"About how much do you weigh without shoes?" and "About how tall are you without shoes?"

These responses were combined to determine a respondent's Body Mass Index (BMI). BMI is calculated as weight in kilograms divided by height in meters squared. Persons with a BMI from 25.0-29.9 are considered overweight.

Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

\[ \text{Adults Overweight} = \left( \frac{\text{[Indicator Percentage]} }{100} \right) \times [\text{Total Population}] \]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the Behavioral Risk Factor Surveillance System home page.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

Pedestrian Motor Vehicle Death
Data Background
The National Highway Traffic Safety Administration (NHTSA) is a branch of the Department of Transportation and is dedicated to achieving the highest standards of excellence in motor vehicle and highway safety. The NHTSA is responsible for enforcing Federal Motor Vehicle Safety Standards as well as regulations for motor vehicle theft resistance and fuel economy. With the help of various reporting systems, the NHTSA provides annual reports and data releases on transportation related fatalities, crash statistics, driver registration, and other information.

Methodology
Crash-related data was acquired using the Fatality Analysis Reporting System (FARS) web-based query tool. Fatalities for non-vehicle occupants (pedestrians) were aggregated by county for years 2008-2010 to obtain a total fatality count. Pedestrian death figures do not include fatalities to bicyclists or persons on personal conveyances (scooters, skateboards). Three years of data were averaged to produce an annual fatality figure for each
county ([Total Deaths] / 3). Population data was acquired from the U.S. Census Bureau's 2010 decennial census. Motor-vehicle mortality rates are reported as the average annual fatalities per 100,000 population using the following formula:

\[
\text{Mortality Rate} = \frac{\text{Average Annual Deaths}}{\text{Total Population}} \times 100,000.
\]

Original motor vehicle crash data may be accessed using the FARS query tool.

**Poor Dental Health**

**Data Background**

The Behavioral Risk Factor Surveillance System (BRFSS) is

“... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

*Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.*

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publically available and maintained on the CDC's BRFSS Annual Survey Data web page.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

**Methodology**

Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2006-2010. Percentages are generated based on valid responses to the following questions:

> "How many of your permanent teeth have been removed because of tooth decay or gum disease? Include teeth lost to infection, but do not include teeth lost for other reasons, such as injury or orthodontics. (If wisdom teeth are removed because of tooth decay or gum disease, they should be included in the count for lost teeth)."

This indicator represents the percentage of respondents who indicated that they had 6 or more, including all of their permanent teeth extracted. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

\[
\text{Adults Poor Dental Health} = (\frac{\text{Indicator Percentage}}{100}) \times \text{Total Population}.
\]

The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site.
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 20. Data are unreliable when the total number of persons sampled over the survey period is less than 50. Confidence intervals are available when exploring the data through the map viewer.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the Behavioral Risk Factor Surveillance System (BRFSS) interview surveys based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Before the raw survey data files are released, self-identified race and ethnicity variables are recoded by National Center for Health Statistics (NCHS) analysts into the following categories: White, Non-Hispanic; Black, Non-Hispanic; Multiple Race, Non-Hispanic; Other Race, Non-Hispanic; and Hispanic or Latino. Due to sample size constraints, race and ethnicity statistics are only reported at the state and national levels.

Poor General Health
Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is “... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households.”

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Methodology
Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following questions:

"Would you say that in general your health is - Excellent, Very Good, Good, Fair, or Poor?"

Respondents that indicated they had poor overall health are included in the count. Percentages are age-adjusted and only pertain to the non-institutionalized population over age 18. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:
Persons with Poor Health = ([Indicator Percentage] / 100) * [Total Population].

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Population with Any Disability
Data Background
The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year, and five-year estimates are also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008). For more information about this source, including data collection methodology and definitions, refer to the American Community Survey website.

Methodology
Counts for population subgroups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey (ACS). Data represent estimates for the 5 year period 2006-2010. Data are summarized to 2010 census tract boundaries. Disability status is classified in the ACS according to yes/no responses to questions (17 - 19) about specific physical (hearing, vision, ambulatory) and cognitive statuses, and any other status which, if present, would make living in the absence of accommodations difficult or impossible. Indicator statistics are measured as a percentage of the total non-institutionalized population using the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2010 Subject.
**Definitions.**

**Data Limitations**
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

**Premature Death**

**Data Background**
The County Health Rankings (CHR) is a data service of the [University of Wisconsin Population Health Institute](https://www.uwhealth.org/population-health) which measures the health of nearly all counties in the nation and ranks them within states. CHR has been published for the nation's counties annually since 2010, expanding on similar work specific to Wisconsin since 2003. Rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. County Health Rankings is a free public service, providing their wealth of their rankings and source data to the public for download.

For more information and to explore the original data, please visit the [County Health Rankings](https://www.countyhealthrankings.org) website.

**Methodology**
Years of potential life lost (YPLL) data was acquired from the University of Wisconsin’s County Health Rankings (CHR). Potential life lost is defined by CHR as a death occurring before the age of 75. CHR uses 2008 - 2010 three year averages from the [National Vital Statistic System](https://www.cdc.gov/nchs) (NVSS) as the basis for their calculation. NVSS data is compiled from state death records and maintained by the Centers for Disease Control and Prevention. Age-stratified NVSS data is used to calculate the total years of potential life lost to all persons under age 75, by county, using the following formula:

\[
YPLL = [ 75 \times (\text{Number of Deaths Under Age 75}) ] - [ \text{SUM (Age at Death)} ]
\]

To further illustrate, a person dying at age 50 would contribute 25 years of life lost to the YPLL index. YPLL is age-adjusted to the 2000 U.S. population to allow comparison between counties and is reported as a rate per 100,000 people. For more information, please review the County Health Rankings [Premature Death](https://www.countyhealthrankings.org) indicator information.

**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

**Prostate Cancer Incidence**

**Data Background**
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles website provide incidence statistics compiled from state and local cancer registries. Statistics
are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

**Methodology**

Annual incidence rates are acquired for all US states and counties as an average for years 2005-2009 from the State Cancer Profiles: Incidence Rates data tables. Incidence rates provided from this source are age adjusted to the 2000 US standard population. In order to perform aggregate (multi-county or service area) estimates with the data provided, adjusted cancer incidence rates are back-calculated using the following formula:

\[
\text{SUM}([\text{Age-Adjusted Rate}/100,000] \times \text{SUM}[\text{Total Population}]) / \text{SUM}[\text{Total Population}] \times 100,000.
\]

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories by state cancer registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic), and for the white Hispanic and white non-Hispanic population.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored. In addition, because of the impact on Louisiana's population in 2005 due to Hurricanes Katrina/Rita, the cases diagnosed in Louisiana during that period (July - December 2005) are excluded. The count has been suppressed due to data consistency issues.

**Stroke Mortality**

**Data Background**
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times ((\text{Age-Adjusted Rate}/100,000))}{\text{SUM(Total Population)}} \times 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.
Suicide

Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER, VitalStats, and the Health Indicator Warehouse.

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} * ((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} * 100,000.
\]

The specific codes used for reported mortality indicators are listed below.

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data is reported separately for race alone and for ethnicity alone in order to maintain large enough sample sizes for the inclusion of small counties in the disaggregated data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of cases is less than 10 (for each
county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

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