2014 Community Health Needs Assessment
Mercer County, Illinois

Sponsored by
Genesis Medical Center, Aledo Campus

Following the 2013 acquisition of Mercer County Hospital, Genesis Medical Center, Aledo, began the Community Health Needs Assessment (CHNA) process for the first time in 2014. This document details the process and provides a report out of data points related to the CHNA.

Genesis Medical Center, Aledo (GMC-Aledo), primarily serves the area of Mercer County, Illinois. As a former health facility owned by the Illinois county of Mercer, GMC-Aledo retains the label of only hospital within the borders of Mercer County, it’s primary service area. Mercer County has an area of 569 square miles and a population of just under 16,500. The population is over 98% Caucasian.

In 2014 a data gathering survey was done by the Genesis Health System Business Intelligence Center. This data, which is attached to this report, gathered information regarding Detailed Health Indicators, Social and Economic Factors, Physical Environment, Clinical Care, Health Behaviors and Health Outcomes.

Additionally, community meetings were held and representatives from across the county, including the Health Department of Mercer County, were present at those meetings and provided valuable input. The following is a list of organizations and representatives of the community:

- Genesis Health System
- Genesis Medical Center, Aledo
- Genesis Senior Living, Aledo
- Genesis Health Group, Aledo
- Health Department of Mercer County
- Mercer Foundation for Health
- WRMJ
- Community Bible Fellowship
- Crisis Center
- Adonai Community Support Services
- Trinity Presbyterian Church
- YMCA
- Aledo Police Department
- Brookstone of Aledo
- Country Financial Services
- Dennison Funeral Home
- Eagle View Health
- Mercer County Extension Unit
- Community members
After analysis of the data report and discussion amongst the named parties GMC-Aledo identified the following three priorities:

1. Health Related Life & Well-Being: According to CountyHealthRankings.com while Mercer county ranks high in quality of life, it ranks low in length of life. Part of this is related to higher than state averages in adult smoking and alcohol-impaired driving deaths. The community felt that these statistics warranted further action.

2. Nutrition & Weight Status: Mercer County is 3% higher than the state average in obesity. The community group recognizes that there is a perception that it is easier to eat unhealthy foods than it is to eat healthy. Through education and raising awareness of existing programs already in the community, the community hopes to see positive change.

3. Access to Healthcare – Because of the size of the community it is difficult to recruit providers to work in Mercer County. Data shows that there is a significant shortage in physicians for Mercer County. Genesis is committed to recruiting more providers in Mercer County.

Genesis Medical Center, Aledo, as the sole hospital within Mercer County has the resources to influence these goals. As part of a larger health system and health group, GMC-Aledo can leverage resources to address these three priorities. Further information will be included in our Implementation Strategy which will be released in Fall 2015.

This CHNA is considered conducted upon adoption of the CHNA by The Genesis Health System Board of Directors which occurred on June 4, 2015 and posting on the Genesis Health System website at www.genesishealth.com/about/community-benefit/ which occurred on June 9, 2015.
DETAILED HEALTH INDICATORS

DEMOGRAPHICS .............................................................................. 4
Total Population .................................................................................. 4
Median Age ......................................................................................... 5
Population Under Age 18 ...................................................................... 11
Population Age 18-64 ........................................................................... 12
Population Age 65+ ............................................................................... 14
Hispanic Population ............................................................................ 20
Foreign-Born Population ...................................................................... 19
Population with Limited English Proficiency ..................................... 17
Linguistically Isolated Households ...................................................... 16
Population Geographic Mobility ......................................................... 18
Urban and Rural Population ............................................................... 21

SOCIAL & ECONOMIC FACTORS .......................................................... 22
Lack Social or Emotional Support ...................................................... 26
Children Eligible for Free/Reduced Price Lunch ................................... 22
Children in Poverty ............................................................................. 23
High School Graduation Rate .............................................................. 25
Income Over $75,000 (Family) ............................................................... 24
Population in Poverty (100% FPL) ....................................................... 27
Population in Poverty (200% FPL) ....................................................... 28
Population Receiving Medicaid ............................................................ 29
Population with Associate's Level Degree or Higher ......................... 30
Population with No High School Diploma ......................................... 31
Teen Births ......................................................................................... 32
Uninsured Population (Adults) ............................................................... 33
Uninsured Population (Children) .......................................................... 34
Uninsured Population (Total) ............................................................... 35

PHYSICAL ENVIRONMENT .................................................................. 36
Air Quality (Ozone) ............................................................................ 37
Air Quality (Particulate Matter 2.5) ....................................................... 38
Fast Food Restaurant Access ............................................................... 39
Grocery Store Access ....................................................................... 40
Liquor Store Access .......................................................................... 41
Low Income Population with Low Food Access .................................. 42
Park Access ....................................................................................... 43
Population with Low Food Access ...................................................... 44
Recreation and Fitness Facility Access ............................................... 45
SNAP-Approved Food Store Access .................................................. 46
Use of Public Transportation .............................................................. 47
WIC-Approved Food Store Access ..................................................... 48

CLINICAL CARE .................................................................................. 49
Access to Primary Care ....................................................................... 49
Breast Cancer Screening (Mammogram) ............................................. 50
Cervical Cancer Screening (Pap Test) .................................................. 51
Colon Cancer Screening (Sigmoid/Colonoscopy) ............................... 52
Dental Care Utilization (Adult) ............................................................. 53
Diabetes Management (Hemoglobin A1c Test) .................................... 54
Facilities Designated as Health Professional Shortage Areas ............. 55
Federally Qualified Health Centers ..................................................... 56
High Blood Pressure Management .................................................... 57
HIV Screenings .................................................................................. 58
Lack of a Consistent Source of Primary Care ...................................... 59
Pneumonia Vaccinations (Age 65) ....................................................... 60
Population Living in a Health Professional Shortage Area ................. 61
Detailed Health Indicators

The following section details health indicators for Mercer County, Illinois, 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](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.

---

**COMMUNITY HEALTH NEEDS ASSESSMENT**

Advancing Community Health and Well Being

**Full Health Indicators Report**

**DEMOGRAPHICS**

<table>
<thead>
<tr>
<th>Report Area: Mercer County, IL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics // Social &amp; Economic Factors // Physical Environment // Clinical Care // Health Behaviors // Health Outcomes</td>
</tr>
<tr>
<td>Total Population</td>
</tr>
<tr>
<td>Change in Total Population</td>
</tr>
<tr>
<td>Male Population</td>
</tr>
<tr>
<td>Female Population</td>
</tr>
<tr>
<td>Family Households with Children</td>
</tr>
<tr>
<td>Population Under Age 18</td>
</tr>
<tr>
<td>Population Age 0-4</td>
</tr>
<tr>
<td>Population Age 5-17</td>
</tr>
</tbody>
</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**

A total of 16,421 people live in the 561.05 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2008-12 5-year estimates. The population density for this area, estimated at 29.27 persons per square mile, is less than the national average population density of 87.89 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>Mercer County, IL</td>
<td>16,421</td>
<td>561.05</td>
<td>29.27</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>55,504.25</td>
<td>231.04</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,709</td>
<td>3,530,997.60</td>
<td>87.55</td>
</tr>
</tbody>
</table>

### 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>Mercer County, IL</td>
<td>8,109</td>
<td>8,312</td>
<td>49.38%</td>
<td>50.62%</td>
</tr>
<tr>
<td>Illinois</td>
<td>6,291,373</td>
<td>6,532,487</td>
<td>49.06%</td>
<td>50.94%</td>
</tr>
<tr>
<td>United States</td>
<td>152,018,800</td>
<td>157,119,904</td>
<td>49.17%</td>
<td>50.83%</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>Mercer County, IL</td>
<td>933</td>
<td>2,793</td>
<td>1,135</td>
<td>1,642</td>
<td>2,004</td>
<td>2,573</td>
<td>2,330</td>
<td>3,011</td>
</tr>
<tr>
<td>Illinois</td>
<td>832,930</td>
<td>2,279,808</td>
<td>1,251,175</td>
<td>1,774,620</td>
<td>1,730,297</td>
<td>1,854,809</td>
<td>1,477,877</td>
<td>1,622,344</td>
</tr>
<tr>
<td>United States</td>
<td>20,137,84</td>
<td>53,841,97</td>
<td>30,822,83</td>
<td>41,184,28</td>
<td>41,227,50</td>
<td>44,646,97</td>
<td>36,605,80</td>
<td>40,671,44</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>Mercer County, IL</td>
<td>5.68%</td>
<td>17.01%</td>
<td>6.91%</td>
<td>10%</td>
<td>12.20%</td>
<td>15.67%</td>
<td>14.19%</td>
<td>18.34%</td>
</tr>
<tr>
<td>Illinois</td>
<td>6.50%</td>
<td>17.78%</td>
<td>9.76%</td>
<td>13.84%</td>
<td>13.49%</td>
<td>14.46%</td>
<td>11.52%</td>
<td>12.65%</td>
</tr>
<tr>
<td>United States</td>
<td>6.51%</td>
<td>17.42%</td>
<td>9.97%</td>
<td>13.32%</td>
<td>13.34%</td>
<td>14.44%</td>
<td>11.84%</td>
<td>13.16%</td>
</tr>
</tbody>
</table>

![Total Population by Age Groups, Percent](image-url)
## 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>Mercer County, IL</td>
<td>16,058</td>
<td>87</td>
<td>45</td>
<td>19</td>
<td>0</td>
<td>122</td>
<td>90</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,298,731</td>
<td>1,860,471</td>
<td>595,110</td>
<td>26,669</td>
<td>2,907</td>
<td>789,345</td>
<td>250,627</td>
</tr>
<tr>
<td>United States</td>
<td>229,298,912</td>
<td>38,825,848</td>
<td>14,859,795</td>
<td>2,529,100</td>
<td>514,402</td>
<td>14,814,369</td>
<td>8,296,291</td>
</tr>
</tbody>
</table>

### Pie Chart

- **White**: 97.79%
- **Black**: 4.49%
- **Asian**: 0.20%
- **Native American / Alaska Native**: 0.08%
- **Native Hawaiian / Pacific Islander**: 0.03%
- **Some Other Race**: 0.02%
- **Multiple Races**: 0.01%
### 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>Mercer County, IL</td>
<td>97.79%</td>
<td>0.53%</td>
<td>0.27%</td>
<td>0.12%</td>
<td>0%</td>
<td>0.74%</td>
<td>0.55%</td>
</tr>
<tr>
<td>Illinois</td>
<td>72.51%</td>
<td>14.51%</td>
<td>4.64%</td>
<td>0.21%</td>
<td>0.02%</td>
<td>6.16%</td>
<td>1.95%</td>
</tr>
<tr>
<td>United States</td>
<td>74.17%</td>
<td>12.56%</td>
<td>4.81%</td>
<td>0.82%</td>
<td>0.17%</td>
<td>4.79%</td>
<td>2.68%</td>
</tr>
</tbody>
</table>

![Pie chart showing population by race alone, percent](image-url)
### 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>Mercer County, IL</td>
<td>167</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>122</td>
<td>12</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,149,252</td>
<td>25,966</td>
<td>4,622</td>
<td>12,160</td>
<td>436</td>
<td>769,001</td>
<td>65,947</td>
</tr>
<tr>
<td>United States</td>
<td>32,394,938</td>
<td>1,039,257</td>
<td>167,001</td>
<td>478,334</td>
<td>34,339</td>
<td>14,198,178</td>
<td>2,233,228</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>Mercer County, IL</td>
<td>55.12%</td>
<td>0%</td>
<td>0%</td>
<td>0.66%</td>
<td>0%</td>
<td>40.26%</td>
<td>3.96%</td>
</tr>
<tr>
<td>Illinois</td>
<td>56.69%</td>
<td>1.28%</td>
<td>0.23%</td>
<td>0.60%</td>
<td>0.02%</td>
<td>37.93%</td>
<td>3.25%</td>
</tr>
<tr>
<td>United States</td>
<td>64.09%</td>
<td>2.06%</td>
<td>0.33%</td>
<td>0.95%</td>
<td>0.07%</td>
<td>28.09%</td>
<td>4.42%</td>
</tr>
</tbody>
</table>

![Hispanic Population by Race Alone, Percent](image-url)
### 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>Mercer County, IL</td>
<td>15,891</td>
<td>87</td>
<td>45</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>78</td>
</tr>
<tr>
<td>Illinois</td>
<td>8,149,479</td>
<td>1,834,505</td>
<td>590,488</td>
<td>14,509</td>
<td>2,471</td>
<td>20,344</td>
<td>184,680</td>
</tr>
<tr>
<td>United States</td>
<td>196,903,968</td>
<td>37,786,592</td>
<td>14,692,794</td>
<td>2,050,766</td>
<td>480,063</td>
<td>616,191</td>
<td>6,063,063</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>Mercer County, IL</td>
<td>98.59%</td>
<td>0.54%</td>
<td>0.28%</td>
<td>0.11%</td>
<td>0%</td>
<td>0%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Illinois</td>
<td>75.48%</td>
<td>16.99%</td>
<td>5.47%</td>
<td>0.13%</td>
<td>0.02%</td>
<td>0.19%</td>
<td>1.71%</td>
</tr>
<tr>
<td>United States</td>
<td>76.14%</td>
<td>14.61%</td>
<td>5.68%</td>
<td>0.79%</td>
<td>0.19%</td>
<td>0.24%</td>
<td>2.34%</td>
</tr>
</tbody>
</table>

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

- **White**
- **Black**
- **Asian**
- **Native American / Alaska Native**
- **Native Hawaiian / Pacific Islander**
- **Some Other Race**
- **Multiple Races**
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>Mercer County, IL</td>
<td>16,421</td>
<td>3,726</td>
<td>22.69%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>3,112,738</td>
<td>24.27%</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,720</td>
<td>73,979,856</td>
<td>23.93%</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>Mercer County, IL</td>
<td>16,421</td>
<td>9,684</td>
<td>58.97%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>8,088,778</td>
<td>63.08%</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,720</td>
<td>194,487,424</td>
<td>62.91%</td>
</tr>
</tbody>
</table>


Population Age 18-64, Percent by Tract, ACS 2008-12

- Over 63.0%
- 60.1 - 63.0%
- 57.1 - 60.0%
- Under 57.1%
- No Data or Data Suppressed

Population Age 65
An estimated 18.34% percent of the population in the report area according to the U.S. Census Bureau American Community Survey 2008-12 5-year estimates. An estimated total of 3,011 older adults resided in the area during this time period. The number of persons age 65 or older is relevant because 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>Mercer County, IL</td>
<td>16,421</td>
<td>3,011</td>
<td>18.34%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>1,622,344</td>
<td>12.65%</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,720</td>
<td>40,671,440</td>
<td>13.16%</td>
</tr>
</tbody>
</table>


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>Mercer County, IL</td>
<td>16,421</td>
<td>43.70</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>36.60</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,720</td>
<td>37.20</td>
</tr>
</tbody>
</table>


Linguistically Isolated Population
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>Mercer County, IL</td>
<td>15,488</td>
<td>26</td>
<td>0.17%</td>
</tr>
<tr>
<td>Illinois</td>
<td>11,990,930</td>
<td>645,512</td>
<td>5.38%</td>
</tr>
<tr>
<td>United States</td>
<td>289,000,832</td>
<td>14,107,602</td>
<td>4.88%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


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>Mercer County, IL</td>
<td>15,488</td>
<td>15,488</td>
<td>117</td>
<td>0.76%</td>
</tr>
<tr>
<td>Illinois</td>
<td>11,990,930</td>
<td>11,990,930</td>
<td>1,140,966</td>
<td>9.52%</td>
</tr>
<tr>
<td>United States</td>
<td>289,000,832</td>
<td>289,000,824</td>
<td>25,081,124</td>
<td>8.68%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population Geographic Mobility

This indicator reports information about population in-migration by assessing changes in residence within a one year period. Of the 16,201 persons residing in the report area, an estimated 3.27% relocated to the area.
according to the American Community Survey 2011 5-year data. 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>Mercer County, IL</td>
<td>16,201</td>
<td>530</td>
<td>3.27%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,629,925</td>
<td>606,624</td>
<td>4.80%</td>
</tr>
<tr>
<td>United States</td>
<td>305,340,608</td>
<td>18,454,468</td>
<td>6.04%</td>
</tr>
</tbody>
</table>


Population Migrated from Outside of the County, State, or Country, Percent of Total Population by Tract, ACS 2008-12

- Over 8.0%
- 5.1 - 8.0%
- 2.1 - 5.0%
- Under 2.1%
- 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. The latest figures from the U.S. Census Bureau show that 117 persons in the report area are of foreign birth, which represents 0.71% of the report area population. This percentage is less than the national rate of 12.87%.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,421</td>
<td>81</td>
<td>36</td>
<td>117</td>
<td>0.71%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,823,860</td>
<td>802,068</td>
<td>966,237</td>
<td>1,768,305</td>
<td>13.79%</td>
</tr>
<tr>
<td>United States</td>
<td>309,138,720</td>
<td>17,639,208</td>
<td>22,145,098</td>
<td>39,784,304</td>
<td>12.87%</td>
</tr>
</tbody>
</table>


Hispanic Population

The estimated population that is of Hispanic, Latino, or Spanish origin in the report area is 303. This represents 1.85% of the total report area population, which is less than the national 16.05% rate. 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.
### Mercer County, IL

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Hispanic or Latino Population</th>
<th>Hispanic Population Hispanic or Latino</th>
<th>Non-Hispanic Population</th>
<th>Percent Population Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,421</td>
<td>303</td>
<td>1.85%</td>
<td>16,118</td>
<td>98.15%</td>
</tr>
</tbody>
</table>

| Illinois             | 12,823,860       | 2,027,384                    | 15.81%                                | 10,796,476              | 84.19%                        |

| United States        | 309,138,720      | 50,545,276                   | 16.35%                                | 258,593,440             | 83.65%                        |


#### 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>Mercer County, IL</td>
<td>16,434</td>
<td>3,655</td>
<td>12,779</td>
<td>22.24%</td>
<td>77.76%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>11,353,553</td>
<td>1,477,079</td>
<td>88.49%</td>
<td>11.51%</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>


### 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.

Children Eligible for Free/Reduced Price Lunch
Within the report area 616 public school students or 28.47% are eligible for Free/Reduced Price lunch out of 2,164 total students enrolled. 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>Mercer County, IL</td>
<td>2,164</td>
<td>616</td>
<td>28.47%</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,082,028</td>
<td>921,148</td>
<td>44.24%</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. Data breakout by demographic groups are not available.

Data Source: National Center for Education Statistics, NCES - Common Core of Data: 2010-11.
Source geography: Address.

Students Eligible for Free or Reduced-Price Lunch by Location, NCES CCD 2010-11

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>Mercer County, IL</td>
<td>16,215</td>
<td>3,724</td>
<td>632</td>
<td>16.97%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,522,726</td>
<td>3,072,262</td>
<td>591,414</td>
<td>19.25%</td>
</tr>
<tr>
<td>United States</td>
<td>301,333,408</td>
<td>72,869,120</td>
<td>15,188,844</td>
<td>20.84%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Families with Income Over $75,000

In the report area, 39.12%, or 1,938 families report a 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.
### Family Income Over $75,000, Percent by Tract, ACS 2007-11

- **Over 55.0%**
- **37.1 - 55.0%**
- **23.1 - 37.0%**
- **Under 23.1%**
- **No Data or Data Suppressed**

**Report Area**

<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>Mercer County, IL</td>
<td>4,954</td>
<td>1,938</td>
<td><strong>39.12%</strong></td>
</tr>
<tr>
<td>Illinois</td>
<td>3,142,347</td>
<td>1,464,262</td>
<td>46.60%</td>
</tr>
<tr>
<td>United States</td>
<td>76,595,552</td>
<td>32,616,244</td>
<td>42.58%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average.*


---

**High School Graduation Rate (NCES)**

Within the report area no data% of students are receiving their high school diploma within four years. This is greater than the Healthy People 2020 target of 82.4%. This indicator is relevant because research suggests education is one the strongest predictors of health (Freudenberg & Ruglis, 2007).
### Lack of 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 or 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>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Without Adequate Social / Emotional Support</th>
<th>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,742</td>
<td>no data</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>1,969,539</td>
<td>20.40%</td>
<td>20.40%</td>
</tr>
<tr>
<td>United States</td>
<td>232,556,016</td>
<td>48,104,656</td>
<td>20.69%</td>
<td>20.68%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


### Inadequate Social/Emotional Support, Percent of Adults Age 18 by County, BRFSS 2006-12

- Over 23.0%
- 19.1 - 23.0%
- 15.1 - 19.0%
- Under 15.1%
- No Data or Data Suppressed
- Report Area

### Population in Poverty - 100% FPL

Poverty is considered a key driver of health status.

Within the report area 10.39% or 1,685 individuals are 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 necessitities 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>Mercer County, IL</td>
<td>16,215</td>
<td>1,685</td>
<td>10.39%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,522,726</td>
<td>1,710,465</td>
<td>13.66%</td>
</tr>
<tr>
<td>United States</td>
<td>301,333,408</td>
<td>44,852,528</td>
<td>14.88%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Population Below the Poverty Level, Percent by Tract, ACS 2008-12

- **Over 20.0%**
- **15.1 - 20.0%**
- **10.1 - 15.0%**
- **Under 10.1%**
- **No Data or Data Suppressed**

Report Area
Population in Poverty - 200% FPL

In the report area 26.77% or 4,340 individuals are 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>Mercer County, IL</td>
<td>16,215</td>
<td>4,340</td>
<td>26.77%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,522,726</td>
<td>3,859,869</td>
<td>30.82%</td>
</tr>
<tr>
<td>United States</td>
<td>301,333,408</td>
<td>101,133,072</td>
<td>33.56%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Population Below 200% Poverty Level, Percent by Tract, ACS 2008-12

- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Report Area

Population Receiving Medicaid

28
This indicator reports the percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). 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>Total Population (For Whom Insurance Status is Determined)</th>
<th>Population with Any Health Insurance</th>
<th>Population Receiving Medicaid</th>
<th>Percent of Insured Population Receiving Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,206</td>
<td>14,987</td>
<td>2,765</td>
<td>18.45%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,641,685</td>
<td>11,009,632</td>
<td>2,137,465</td>
<td>19.41%</td>
</tr>
<tr>
<td>United States</td>
<td>303,984,256</td>
<td>258,778,080</td>
<td>50,682,900</td>
<td>19.59%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Population with Associate’s Level Degree or Higher

24.02% of the population aged 25 and older, or 2,777 have obtained an Associate’s level degree or higher. This indicator is relevant because educational attainment has been linked to positive health outcomes.
<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>Mercer County, IL</td>
<td>11,560</td>
<td>2,777</td>
<td>24.02%</td>
</tr>
<tr>
<td>Illinois</td>
<td>8,459,947</td>
<td>3,251,304</td>
<td>38.43%</td>
</tr>
<tr>
<td>United States</td>
<td>204,336,016</td>
<td>73,941,024</td>
<td>36.19%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Population with an Associate Level Degree or Higher, Percent by Tract, ACS 2008-12

- Over 32.0%
- 26.1 - 32.0%
- 20.1 - 26.0%
- Under 20.1%
- No Data or Data Suppressed

Report Area

Population with No High School Diploma
Within the report area there are 1,258 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 10.88% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes (Freudenberg & Ruglis, 2007).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>11,560</td>
<td>1,258</td>
<td>10.88%</td>
</tr>
<tr>
<td>Illinois</td>
<td>8,459,947</td>
<td>1,102,449</td>
<td>13.03%</td>
</tr>
<tr>
<td>United States</td>
<td>204,336,016</td>
<td>29,179,820</td>
<td>14.28%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Population with No High School Diploma, Percent by Tract, ACS 2008-12

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed

**Teen Births**

This indicator reports the rate of total births to women 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 Population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>489</td>
<td>16</td>
<td>33.20</td>
</tr>
<tr>
<td>Illinois</td>
<td>448,356</td>
<td>15,692</td>
<td>35</td>
</tr>
<tr>
<td>United States</td>
<td>10,736,677</td>
<td>392,962</td>
<td>36.60</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Births to Females Age 15-19, Rate (Per 1,000 Pop.) by County, NVSS 2006-12

Uninsured Population - Adults

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

This indicator reports the percentage of adults age 18 to 64 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>Mercer County, IL</td>
<td>9,401</td>
<td>8,076</td>
<td>85.90%</td>
<td>1,325</td>
<td>14.10%</td>
</tr>
<tr>
<td>Illinois</td>
<td>7,918,885</td>
<td>6,429,092</td>
<td>81.19%</td>
<td>1,489,794</td>
<td>18.81%</td>
</tr>
<tr>
<td>United States</td>
<td>191,640,968</td>
<td>151,849,368</td>
<td>79.24%</td>
<td>39,791,596</td>
<td>20.76%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Uninsured Population, Age 18-64, Percent by County, SAHIE 2012

<table>
<thead>
<tr>
<th>Uninsured Population - Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>The lack of health insurance is considered a <strong>key driver</strong> of health status.</td>
</tr>
<tr>
<td>This indicator reports the percentage of children under age 19 without health insurance coverage. This</td>
</tr>
</tbody>
</table>
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>Mercer County, IL</td>
<td>3,741</td>
<td>3,617</td>
<td>96.70%</td>
<td>125</td>
<td>3.30%</td>
</tr>
<tr>
<td>Illinois</td>
<td>3,182,408</td>
<td>3,064,448</td>
<td>96.29%</td>
<td>117,960</td>
<td>3.71%</td>
</tr>
<tr>
<td>United States</td>
<td>76,468,844</td>
<td>70,705,585</td>
<td>92.46%</td>
<td>5,763,259</td>
<td>7.54%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Uninsured Population, Age 0-18, Percent by County, SAHIE 2012

- Over 10.0%
- 8.1 - 10.0%
- 6.1 - 8.0%
- Under 6.1%
- No Data or Data Suppressed
- Report Area

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>Total Uninsured Population</th>
<th>Percent Uninsured Population</th>
<th>Percent Uninsured Population, Margin of Error (±)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,206</td>
<td>1,219</td>
<td>7.52%</td>
<td>1.05%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,641,685</td>
<td>1,632,053</td>
<td>12.91%</td>
<td>0.07%</td>
</tr>
<tr>
<td>United States</td>
<td>303,984,256</td>
<td>45,206,152</td>
<td>14.87%</td>
<td>0.04%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


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

Within the report area, 0, or 0% of days exceeded the emission standard of 75 parts per billion (ppb). 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 Emissions Standards, Crude Average</th>
<th>Percentage of Days Exceeding Emissions Standards, Pop. Adjusted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>37.13</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>35.28</td>
<td>0.03</td>
<td>0.01%</td>
<td>0.01%</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. Data breakout by demographic groups are not available.

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>Mercer County, IL</td>
<td>16,434</td>
<td>9.54</td>
<td>1</td>
<td>0.27%</td>
<td>0.27%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>12.46</td>
<td>4.15</td>
<td>1.14%</td>
<td>1.08%</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. Data breakout by demographic groups are not available.


Fine Particulate Matter Levels (PM 2.5), Percent Days Above NAAQ Standards by Tract, NEPHTN 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>Establishments, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>5</td>
<td>30.42</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>9,591</td>
<td>74.75</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>224,877</td>
<td>71.97</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES. Source geography: County.

Fast Food Restaurants, Rate (Per 100,000 Pop.) by County, CBP 2012

- Over 100.0
- 75.1 - 100.0
- 50.1 - 75.0
- Under 50.1
- No Fast Food Restaurants
- Report Area

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>Establishments, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>2</td>
<td>12.17</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>2,887</td>
<td>22.50</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>66,047</td>
<td>21.14</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data Source: US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES. Source geography: County.

Grocery Stores and Supermarkets, Rate (Per 100,000 Pop.) by County, CBP 2012

- 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>Establishments, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>1</td>
<td>6.08</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>1,326</td>
<td>10.33</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>32,327</td>
<td>10.35</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES. Source geography: County.

Beer, Wine and Liquor Stores, Rate (Per 100,000 Pop.) by County, CBP 2012

- Over 18.0
- 12.1 - 18.0
- 6.1 - 12.0
- Under 6.1
- No Beer, Wine, or Liquor Stores

Report Area

Low Income Population with Low Food Access
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>1,829</td>
<td>11.13%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>584,658</td>
<td>4.56%</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. Data breakout by demographic groups are not available.


---

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

- Over 50.0%
- 20.1 - 50.0%
- 5.1 - 20.0%
- Under 5.1%
- No Low Food Access
- Report Area

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, 2010 Census</th>
<th>Population Within 1/2 Mile of a Park</th>
<th>Percent Within 1/2 Mile of a Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>3,349</td>
<td>20.38%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>7,024,779</td>
<td>54.75%</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>112,471,792</td>
<td>38.01%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.*

Data Source: ESRI Map Gallery: 2013, OpenStreetMap: 2013. Additional data analysis by CARES.

Source geography: Tract.

### 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>Mercer County, IL</td>
<td>16,434</td>
<td>4,601</td>
<td>28%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>2,623,048</td>
<td>20.44%</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. Data breakout by demographic groups are not available.


Population with Limited Food Access, Percent by Tract, FARA 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>Establishments, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>2</td>
<td>12.17</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>1,290</td>
<td>10.05</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>29,511</td>
<td>9.44</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES. Source geography: County.

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>Total SNAP-Authorized Retailers</th>
<th>SNAP-Authorized Retailers, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>14</td>
<td>85.19</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>9,129</td>
<td>71.15</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>245,113</td>
<td>78.44</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


### SNAP-Authorized Retailers, Rate per 10,000 Population by Tract, USDA SNAP Locator 2014

- **Over 12.0**
- **6.1 - 12.0**
- **Under 6.0**
- **No SNAP-Authorized Retailers**
- **No Population or No Data**

Report Area
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>Mercer County, IL</td>
<td>8,004</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>5,926,796</td>
<td>516,053</td>
<td>8.71</td>
</tr>
<tr>
<td>United States</td>
<td>139,893,632</td>
<td>6,967,689</td>
<td>4.98</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Workers Traveling to Work Using Public Transit, Percent by Tract, ACS 2008-12

- Over 4.0%
- 1.1 - 4.0%
- 0.1 - 1.0%
- No Workers Using Public Transit
- No Data or Data Suppressed

Report Area
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>Mercer County, IL</td>
<td>16,363</td>
<td>3</td>
<td>18.33</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,936,505</td>
<td>2,390</td>
<td>18.40</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. Data breakout by demographic groups are not available.


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

- Over 30.0
- 15.1 - 30.0
- Under 15.1
- No WIC-Authorized Retailers
- No Data or Data Suppressed
- Report Area

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, 2011</th>
<th>Total Primary Care Physicians, 2011</th>
<th>Primary Care Physicians, Rate per 100,000 Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,363</td>
<td>4</td>
<td>24.45</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,869,257</td>
<td>12,353</td>
<td>95.99</td>
</tr>
<tr>
<td>United States</td>
<td>311,591,917</td>
<td>267,437</td>
<td>85.83</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


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>Mercer County, IL</td>
<td>2,714</td>
<td>236</td>
<td>152</td>
<td>64.83%</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,287,225</td>
<td>106,907</td>
<td>70,014</td>
<td>65.49%</td>
</tr>
<tr>
<td>United States</td>
<td>51,875,184</td>
<td>4,218,820</td>
<td>2,757,677</td>
<td>65.37%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Mammogram (Past 2 Years), Percent of Female Medicare Enrollees, Age 67-69 by County, DA 2010

- Over 72.0%
- 64.1 - 72.0%
- 56.1 - 64.0%
- Under 56.1%
- No Data or Data Suppressed

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 Number with Regular Pap Test</th>
<th>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,531</td>
<td>no data</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>7,174,065</td>
<td>5,538,378</td>
<td>77.20%</td>
<td>78.30%</td>
</tr>
<tr>
<td>United States</td>
<td>176,847,182</td>
<td>137,191,142</td>
<td>77.58%</td>
<td>78.48%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Cervical Cancer Screening (Past 3 Years), Percent of Women Age 18 by County, BRFSS 2006-12

- Over 84.0%
- 80.1 - 84.0%
- 76.1 - 80.0%
- Under 76.1%
- No Data or Data Suppressed

Cancer Screening - Sigmoidoscopy or Colonoscopy

This indicator reports the percentage of adults 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>Report Area</th>
<th>Total Population Age 50</th>
<th>Estimated Population Ever Screened for Colon Cancer</th>
<th>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>5,272</td>
<td>no data</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>3,027,371</td>
<td>1,843,669</td>
<td>60.90%</td>
<td>57.70%</td>
</tr>
<tr>
<td>United States</td>
<td>75,116,406</td>
<td>48,549,269</td>
<td>64.63%</td>
<td>61.34%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


Colon Cancer Screening (Ever), Percent of Adults Age 50 by County, BRFSS 2006-12

- Over 62.0%
- 55.1 - 62.0%
- 48.1 - 55.0%
- Under 48.1%
- No Data or Data Suppressed

Dental Care Utilization

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>Mercer County, IL</td>
<td>12,754</td>
<td>7,123</td>
<td>55.85%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>2,981,670</td>
<td>30.88%</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.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES. Source geography: County.

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. In the report area, 259 Medicare enrollees with diabetes have had an annual exam out of 319 Medicare enrollees in the report area with diabetes, or 81.50%. 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.
### Patients with Annual HA1C Test (Diabetes), Percent of Medicare Enrollees with Diabetes by County, DA 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>Mercer County, IL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Note

This indicator is compared with the state average. Data breakout by demographic groups are not available.

<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>Mercer County, IL</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>106</td>
<td>84</td>
<td>77</td>
<td>267</td>
</tr>
<tr>
<td>United States</td>
<td>3,313</td>
<td>2,751</td>
<td>2,704</td>
<td>8,768</td>
</tr>
</tbody>
</table>

*Note: Data breakout by demographic groups are not available.*


### 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>Mercer County, IL</td>
<td>16,434</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,830,632</td>
<td>367</td>
<td>2.86</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>6,482</td>
<td>2.07</td>
</tr>
</tbody>
</table>

Note: Data breakout by demographic groups are not available.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, [Provider of Services File](#): 2013.
Source geography: Address.

High Blood Pressure Management

In the report area, no data of adults, or no data, self-reported that they are not taking medication for their high blood pressure according to the CDC's Behavioural Risk Factor Surveillance System (2006-2010). This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health issues.
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>Mercer County, IL</td>
<td>12,754</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>2,116,424</td>
<td>21.92%</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.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES. Source geography: County.

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.
## 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.
### No Consistent Source of Primary Care, Percent of Adults Age 18 by County, BRFSS 2011-12

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Survey Population (Adults Age 18)</th>
<th>Total Adults Without Any Regular Doctor</th>
<th>Percent Adults Without Any Regular Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,145</td>
<td>3,880</td>
<td><strong>24.03%</strong></td>
</tr>
<tr>
<td>Illinois</td>
<td>9,702,848</td>
<td>1,743,367</td>
<td><strong>17.97%</strong></td>
</tr>
<tr>
<td>United States</td>
<td>236,884,668</td>
<td>52,290,932</td>
<td><strong>22.07%</strong></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


---

### Pneumonia Vaccination

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.
### Annual Pneumonia Vaccination, Percent of Adults Age 65 by County, BRFSS 2006-12

- **Over 72.0%**
- **68.1 - 72.0%**
- **64.1 - 68.0%**
- **Under 64.1%**
- **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>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,434</td>
<td>16,206</td>
<td>10,256</td>
<td>63.29%</td>
</tr>
<tr>
<td>Illinois</td>
<td>5,993,089</td>
<td>3,392,149</td>
<td>1,254,345</td>
<td>36.98%</td>
</tr>
<tr>
<td>United States</td>
<td>107,167,492</td>
<td>58,371,691</td>
<td>21,919,540</td>
<td>37.55%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas: April 2014. Source geography: HPSA.

### 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>Mercer County, IL</td>
<td>2,808</td>
<td>168</td>
<td>59.83</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,365,587</td>
<td>102,364</td>
<td>74.96</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. Data breakout by demographic groups are not available.


### 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 on average for men and one drink per day on average 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 Number Drinking Excessively</th>
<th>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,742</td>
<td>no data</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>1,930,921</td>
<td>20%</td>
<td>20.40%</td>
</tr>
<tr>
<td>United States</td>
<td>232,556,016</td>
<td>38,248,349</td>
<td>16.45%</td>
<td>16.94%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


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>Mercer County, IL</td>
<td>no data</td>
<td>no data</td>
<td>32</td>
<td>31.37%</td>
<td>no data</td>
</tr>
<tr>
<td>Illinois</td>
<td>52,831</td>
<td>923</td>
<td>no data</td>
<td>no data</td>
<td>1.75%</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. Data breakout by demographic groups are not available.


### Alcohol Beverage Expenditures, Percent of Total Expenditures, National Rank by Tract, Nielsen 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
- Report Area

### Fruit/Vegetable Consumption

In the report area an estimated no data, or suppressed of adults over the age of 18 are 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 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>Mercer County, IL</td>
<td>12,668</td>
<td>no data</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,591,923</td>
<td>7,318,637</td>
<td>76.30%</td>
</tr>
<tr>
<td>United States</td>
<td>227,279,010</td>
<td>171,972,118</td>
<td>75.67%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


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>Fruit / Vegetable Expenditures, County Percentile</th>
<th>Percent Fruit / Vegetable Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>no data</td>
<td>no data</td>
<td>51</td>
<td>50%</td>
<td>no data</td>
</tr>
<tr>
<td>Illinois</td>
<td>52,831</td>
<td>722</td>
<td>no data</td>
<td>no data</td>
<td>1.37%</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>737</td>
<td>no data</td>
<td>no data</td>
<td>1.45%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


**Physical Inactivity**

Within the report area, 3,346 or 25.30% of adults aged 20 and older 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>Mercer County, IL</td>
<td>12,347</td>
<td>3,346</td>
<td>25.30%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,361,500</td>
<td>2,217,069</td>
<td>23.42%</td>
</tr>
<tr>
<td>United States</td>
<td>226,142,005</td>
<td>53,729,295</td>
<td>23.41%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *Diabetes Atlas*: 2010. Source geography: County.

No Leisure-Time Physical Activity, Adults Age 20, Percent by County, CDC NCCDPHP 2010

- Over 29.0%
- 26.1 - 29.0%
- 23.1 - 26.0%
- Under 23.1%
- Report Area

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>Mercer County, IL</td>
<td>no data</td>
<td>no data</td>
<td>35</td>
<td>34.31%</td>
<td>no data</td>
</tr>
<tr>
<td>Illinois</td>
<td>52,831</td>
<td>267</td>
<td>no data</td>
<td>no data</td>
<td>0.50%</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. Data breakout by demographic groups are not available.*


### 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.
### Tobacco Usage - Current Smokers

In the report area an estimated 4,103, or 32.20% of adults age 18 or older 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>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,742</td>
<td>4,103</td>
<td>32.20%</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>1,766,792</td>
<td>18.30%</td>
<td>18.40%</td>
</tr>
<tr>
<td>United States</td>
<td>232,556,016</td>
<td>41,491,223</td>
<td>17.84%</td>
<td>18.08%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.


### Tobacco Usage - Former or Current Smokers

In the report area, an estimated 10,469 adults, or 64.84%, report ever smoking 100 or more cigarettes. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.
### Percent Adults Ever Smoking 100 or More Cigarettes

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Survey Population (Adults 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>Mercer County, IL</td>
<td>16,146</td>
<td>10,469</td>
<td>64.84%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,659,812</td>
<td>4,258,470</td>
<td>44.08%</td>
</tr>
<tr>
<td>United States</td>
<td>235,151,778</td>
<td>103,842,020</td>
<td>44.16%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


### Tobacco Usage - Quit Attempt

An estimated 64.74% of adult smokers in the report area attempted to quit smoking for at least 1 day in the past year. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease and supporting efforts to quit smoking may increase positive health outcomes.
<table>
<thead>
<tr>
<th>Report Area</th>
<th>Survey Population (Smokers 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>Mercer County, IL</td>
<td>6,771</td>
<td>4,383</td>
<td>64.74%</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,903,115</td>
<td>1,164,973</td>
<td>61.21%</td>
</tr>
<tr>
<td>United States</td>
<td>45,526,654</td>
<td>27,323,073</td>
<td>60.02%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


**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.

**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>Survey Population (Adults Age 18)</th>
<th>Total Adults with Asthma</th>
<th>Percent Adults with Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,145</td>
<td>3,354</td>
<td>20.77%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,701,927</td>
<td>1,265,744</td>
<td>13.05%</td>
</tr>
<tr>
<td>United States</td>
<td>237,197,465</td>
<td>31,697,608</td>
<td>13.36%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Asthma (Diagnosed), Percent of Adults Age 18 by County, BRFSS 2011-12

Cancer Incidence - Breast

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.
Cancer Incidence - Colon and Rectum

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 2006-2010</th>
<th>Annual Cancer Incidence, 2006-2010 Average</th>
<th>Annual Incidence Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,551</td>
<td>11</td>
<td>46.30</td>
</tr>
<tr>
<td>Illinois</td>
<td>11,069,849</td>
<td>6,613</td>
<td>50.10</td>
</tr>
<tr>
<td>United States</td>
<td>303,965,280</td>
<td>141,281</td>
<td>43.90</td>
</tr>
</tbody>
</table>

**HP 2020 Target**

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

Data Source: [State Cancer Profiles](http://statecancerprofiles.org): 2006-10. Source geography: County.

---

### Colo-Rectal Cancer, Incidence Rate (Per 100,000 Pop.) by County, State Cancer Profiles 2006-10

- Over 53.0
- 47.1 - 53.0
- 41.1 - 47.0
- Under 41.1
- No Data or Data Suppressed

---

**Cancer Incidence - Lung**

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 2006-2010</th>
<th>Annual Cancer Incidence, 2006-2010 Average</th>
<th>Annual Incidence Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,551</td>
<td>15</td>
<td>65.20</td>
</tr>
<tr>
<td>Illinois</td>
<td>11,069,849</td>
<td>9,308</td>
<td>71.40</td>
</tr>
<tr>
<td>United States</td>
<td>303,965,280</td>
<td>208,652</td>
<td>64.90</td>
</tr>
</tbody>
</table>

**Note:** This indicator is compared with the state average.

Data Source: [State Cancer Profiles](#): 2006-10. Source geography: County.

**Cancer Incidence - Prostate**

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.
### Annual Cancer Incidence, 2006-2010

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Male Population, ACS 2006-2010</th>
<th>Annual Cancer Incidence, 2006-2010 Average</th>
<th>Annual Incidence Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>8,127</td>
<td>16</td>
<td>149.80</td>
</tr>
<tr>
<td>Illinois</td>
<td>5,413,034</td>
<td>9,194</td>
<td>153.90</td>
</tr>
<tr>
<td>United States</td>
<td>149,398,720</td>
<td>215,232</td>
<td>143.70</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average.*

*Data Source: [State Cancer Profiles](#); 2006-10. Source geography: County.*

#### Prostate Cancer, Incidence Rate (Per 100,000 Pop.) by County, State Cancer Profiles 2006-10

<table>
<thead>
<tr>
<th></th>
<th>Over 160.0</th>
<th>140.1 - 160.0</th>
<th>120.1 - 140.0</th>
<th>Under 120.1</th>
<th>No Data or Data Suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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</th>
<th>Total Chlamydia Infections</th>
<th>Chlamydia Infection Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,363</td>
<td>37</td>
<td>226.10</td>
</tr>
</tbody>
</table>

**Chlamydia Infection Rate (Per 100,000 Pop.)**
<table>
<thead>
<tr>
<th></th>
<th>Total Population Age 20</th>
<th>Population with Diagnosed Diabetes</th>
<th>Population with Diagnosed Diabetes, Crude Rate</th>
<th>Population with Diagnosed Diabetes, Age-Adjusted Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Illinois</strong></td>
<td>12,869,257</td>
<td>67,701</td>
<td>526.07</td>
<td></td>
</tr>
<tr>
<td><strong>United States</strong></td>
<td>311,577,841</td>
<td>1,422,976</td>
<td>456.70</td>
<td></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


### Diabetes (Adult)

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.

---

Chlamydia, Infection Rate per 100,000 Population by County, NCHHSTP 2012

- Over 500.0
- 300.1 - 500.0
- 150.1 - 300.0
- Under 150.1
- No Data or Data Suppressed

Report Area

---

![Map](image-url)
### Diabetes Prevalence, Percent of Adults Age 20 by County, CDC NCCDPHP 2010

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Gonorrhea Infections</th>
<th>Gonorrhea Infection Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,364</td>
<td>1,224</td>
<td>9.90</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,356,367</td>
<td>844,839</td>
<td>9.03</td>
</tr>
<tr>
<td>United States</td>
<td>228,834,127</td>
<td>21,876,232</td>
<td>9.56</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *Diabetes Atlas* 2010. Source geography: County.

### 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>Total Population</th>
<th>Total Gonorrhea Infections</th>
<th>Gonorrhea Infection Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,363</td>
<td>1</td>
<td>6.10</td>
</tr>
<tr>
<td>Illinois</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Gonorrhea Infection Rate (Per 100,000 Pop.)

- Mercer County, IL (6.10)
- (0)
United States | 311,466,046 | 334,826 | 107.50

Note: This indicator is compared with the state average.


Gonorrhea, Infection Rate per 100,000 Population by County, NCHHSTP 2012

Heart Disease (Adult)

1,873, or 11.60% 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>Survey Population (Adults Age 18)</th>
<th>Total Adults with Heart Disease</th>
<th>Percent Adults with Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>16,146</td>
<td>1,873</td>
<td>11.60%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,681,141</td>
<td>369,926</td>
<td>3.82%</td>
</tr>
</tbody>
</table>
Heart Disease (Diagnosed), Percent of Adults Age 18 by County, BRFSS 2011-12

- Over 7.0%
- 5.1 - 7.0%
- 3.1 - 5.0%
- 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>Total Population</th>
<th>Population with HIV / AIDS</th>
<th>Population with HIV / AIDS, Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>13,803</td>
<td>5</td>
<td>33.50</td>
</tr>
<tr>
<td>Illinois</td>
<td>10,624,597</td>
<td>31,884</td>
<td>300.10</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

HIV Prevalence, Rate (Per 100,000 Pop.) by County, NCHHSTP 2010

- 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.
**Low Birth Weight**

This indicator reports the percentage of total births that are 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 Live Births</th>
<th>Low Weight Births (Under 2500g)</th>
<th>Low Weight Births, Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>1,204</td>
<td>69</td>
<td>5.70%</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,251,656</td>
<td>105,139</td>
<td>8.40%</td>
</tr>
</tbody>
</table>

**Infant Mortality, Rate (Per 1,000 Live Births) by County, AHRF 2006-10**

- Over 10.0
- 8.1 - 10.0
- 5.1 - 8.0
- Under 5.1
- No Data or Data Suppressed

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

**Low Birth Weight, Percent of Live Births by County, NVSS 2006-12**

- Over 10.0%
- 8.1 - 10.0%
- 6.1 - 8.0%
- Under 6.1%
- No Data or Data Suppressed

**Report Area**

<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>Mercer County, IL</td>
<td>16,552</td>
<td>35</td>
<td>212.66</td>
<td>154.53</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,742,854</td>
<td>24,151</td>
<td>189.52</td>
<td>184.08</td>
</tr>
</tbody>
</table>

**United States**

- 29,300,495
- 2,402,641
- 8.20%

**HP 2020 Target**

- <=7.8%

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


---

**Mortality - Cancer**

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.
Mortality - Heart Disease

Within the report area the rate of death due to coronary heart disease per 100,000 population is 175.96. 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>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>227.79</td>
<td>137.95</td>
</tr>
<tr>
<td>Illinois</td>
<td>242.67</td>
<td>155.14</td>
</tr>
<tr>
<td>United States</td>
<td>237.96</td>
<td>154.19</td>
</tr>
</tbody>
</table>

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

Population by Gender, Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.)

Note: This indicator is compared with the state average.
Accessed via CDC WONDER. Source geography: County.
Mortality - Lung Disease

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>Mercer County, IL</td>
<td>16,552</td>
<td>16</td>
<td>94.25</td>
<td><strong>62.63</strong></td>
</tr>
<tr>
<td>Illinois</td>
<td>12,742,854</td>
<td>5,121</td>
<td>40.19</td>
<td>39.46</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.


---

**Lung Disease Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 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

Report Area

---

**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>Mercer County, IL</td>
<td>71.59</td>
<td>55.94</td>
</tr>
</tbody>
</table>
Report Area | Male | Female
---|---|---
Illinois | 46.94 | 34.87
United States | 49.56 | 37.82

**Mortality - Motor Vehicle Accident**

This indicator reports the rate of death due to motor vehicle crashes per 100,000 population, which include collisions with another motor vehicle, a nonmotorist, 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>Mercer County, IL</td>
<td>16,552</td>
<td>3</td>
<td>16.92</td>
<td>21.82</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,742,854</td>
<td>1,211</td>
<td>9.51</td>
<td>9.41</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. Data breakout by demographic groups are not available.

Accessed via CDC WONDER. Source geography: County.

Motor Vehicle Accident Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 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
- Report Area

Mortality - Pedestrian Accident

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.
### Mercer County, IL

<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>Mercer County, IL</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>360</td>
<td>120</td>
<td>0.90</td>
</tr>
<tr>
<td>United States</td>
<td>12,750</td>
<td>4,250</td>
<td>1.38</td>
</tr>
</tbody>
</table>

**HP 2020 Target** <= 1.3

**Data Source:** US Department of Transportation, National Highway Traffic Safety Administration; 2008-10. Source geography: County.

**Note:** This indicator is compared with the Healthy People 2020 Target. Data breakout by demographic groups are not available.

---

### Mortality - 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>Mercer County, IL</td>
<td>16,363</td>
<td>58</td>
<td>987</td>
<td>6,029</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,869,257</td>
<td>42,933</td>
<td>853,004</td>
<td>6,628</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. Data breakout by demographic groups are not available.*

*Data Source: University of Wisconsin Population Health Institute, [County Health Rankings]: 2008-10.*

*Source geography: County.*

### Mortality - Stroke

Within the report area there are an estimated 30.99 deaths due to cerebrovascular disease (stroke) per 100,000 population. This is less than the Healthy People 2020 target of less than or equal to 33.8. 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>Mercer County, IL</td>
<td>16,552</td>
<td>7</td>
<td>43.50</td>
<td>30.99</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,742,854</td>
<td>5,650</td>
<td>44.34</td>
<td>42.48</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><strong>HP 2020 Target</strong></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.


### Stroke Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 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>Mercer County, IL</td>
<td>22.38</td>
<td>38.44</td>
</tr>
<tr>
<td>Illinois</td>
<td>43.29</td>
<td>41.32</td>
</tr>
</tbody>
</table>
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>Mercer County, IL</td>
<td>16,552</td>
<td>2</td>
<td>14.50</td>
<td>15.51</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,742,854</td>
<td>1,134</td>
<td>8.90</td>
<td>8.77</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.

Accessed via CDC WONDER. Source geography: County.

Suicide Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 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
- Report Area

Population by Gender, Suicide 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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Area</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>Mercer County, IL</td>
<td>30.97</td>
<td>no data</td>
</tr>
<tr>
<td>Illinois</td>
<td>14.61</td>
<td>3.45</td>
</tr>
<tr>
<td>United States</td>
<td>18.96</td>
<td>4.77</td>
</tr>
</tbody>
</table>

Obesity

31.80% of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. Excess weight 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 BMI &gt; 30.0 (Obese)</th>
<th>Percent Population with BMI &gt; 30.0 (Obese)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,321</td>
<td>3,992</td>
<td><strong>31.80%</strong></td>
</tr>
<tr>
<td>Illinois</td>
<td>9,354,655</td>
<td>2,590,658</td>
<td><strong>27.37%</strong></td>
</tr>
<tr>
<td>United States</td>
<td>226,126,076</td>
<td>62,144,711</td>
<td><strong>27.29%</strong></td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *Diabetes Atlas*: 2010. Source geography: County.
### Adults Obese (BMI > 35.0) 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>Mercer County, IL</td>
<td>1,975</td>
<td>32.40%</td>
<td>1,874</td>
<td>28.90%</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,598,228</td>
<td>28.35%</td>
<td>2,565,090</td>
<td>26.09%</td>
</tr>
<tr>
<td>United States</td>
<td>62,091,071</td>
<td>28.21%</td>
<td>62,125,142</td>
<td>26.45%</td>
</tr>
</tbody>
</table>

- **Mercer County, IL**: 1,975 males (32.40%) and 1,874 females (28.90%)
- **Illinois**: 2,598,228 males (28.35%) and 2,565,090 females (26.09%)
- **United States**: 62,091,071 males (28.21%) and 62,125,142 females (26.45%)

---

**Overweight**

97
47.91% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) in the report area. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Survey Population (Adults Age 18)</th>
<th>Total Adults Overweight</th>
<th>Percent Adults Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>15,911</td>
<td>7,624</td>
<td>47.91%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,476,490</td>
<td>3,448,247</td>
<td>36.39%</td>
</tr>
<tr>
<td>United States</td>
<td>224,991,207</td>
<td>80,499,532</td>
<td>35.78%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Overweight (BMI 25.0-29.9), Adults Age 18, Percent by County, BRFSS 2011-12

- Over 39.0%
- 36.1 - 39.0%
- 33.1 - 36.0%
- Under 33.1%
- No Data or Data Suppressed

Report Area
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>Mercer County, IL</td>
<td>12,754</td>
<td>2,999</td>
<td>23.51%</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>1,418,280</td>
<td>14.69%</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.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES. Source geography: County.

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

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

Report Area
Within the report area suppressed of adults age 18 and older self-report having poor or fair health in response to the question "Would you say that in general your health is excellent, very good, good, fair, or poor?". 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>Crude Percentage</th>
<th>Age-Adjusted Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercer County, IL</td>
<td>12,742</td>
<td>no data</td>
<td>suppressed</td>
<td>suppressed</td>
</tr>
<tr>
<td>Illinois</td>
<td>9,654,603</td>
<td>1,486,809</td>
<td>15.40%</td>
<td>15.10%</td>
</tr>
<tr>
<td>United States</td>
<td>232,556,016</td>
<td>37,766,703</td>
<td>16.24%</td>
<td>15.74%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.

This indicator reports the percentage of the total civilian noninstitutionalized 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>Total 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>Mercer County, IL</td>
<td>16,206</td>
<td>1,918</td>
<td>11.84%</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,641,685</td>
<td>1,301,381</td>
<td>10.29%</td>
</tr>
<tr>
<td>United States</td>
<td>303,984,256</td>
<td>36,551,036</td>
<td>12.02%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

<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>Mercer County, IL</td>
<td>5.64%</td>
<td>7.63%</td>
<td>34.10%</td>
</tr>
<tr>
<td>Illinois</td>
<td>3.33%</td>
<td>8.09%</td>
<td>35.43%</td>
</tr>
<tr>
<td>United States</td>
<td>4%</td>
<td>10.03%</td>
<td>36.76%</td>
</tr>
</tbody>
</table>

### Population with Any Disability by Age Group, Percent

**Mortality - Unintentional Injury**

---

102
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.

**Age-Adjusted Death Rate, Accident Mortality**

(Per 100,000 Pop.)

- Mercer County, IL (44.32)
- HP 2020 Target (36)
- United States (39.07)

**Unintentional Injury (Accident) Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 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
- Report Area

**FOOTNOTES**

103
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 2008-2012. 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 2012 Subject Definitions.

Notes

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; social and economic data are reported by race or ethnicity alone.

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).

Change in Total 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

The data is downloaded in text format from the U.S. Census Bureau's FTP site for the years 2000 and 2010. The text documents are then uploaded into a SQL database. The demographics indicators are mapped using population provided for county area (Sum Level 050). Total populations are derived directly from data provided. The rate of population change is calculated using Total Population 2010 - Total Population 2000 = Population Change.

Notes

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. 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.

Male 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.
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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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).

Female 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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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).

Family Households with Children

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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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).
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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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 0-4
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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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 5-17**

**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 2008-2012. 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 2012 Subject Definitions](https://www.census.gov). 

**Notes**

**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. 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.

**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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.
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 18-24

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 2008-2012. 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 2012 Subject Definitions.

Notes
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. 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.

**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 25-34**

**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 2008-2012. 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 2012 Subject Definitions.

**Notes**

**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. 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.

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 35-44

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 2008-2012. 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:

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 2012 Subject Definitions.

Notes
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. 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.

**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 45-54**

**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 2008-2012. 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 2012 Subject Definitions](https://www.census.gov/).
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. 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.

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 55-64

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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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 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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Data provided by the census are area estimates; as a median, this indicator cannot be re-summarized or recalculated to aggregate or user-defined geographic boundaries.

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

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. 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.

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).

Linguistically Isolated 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.
Population counts for population by language proficiency 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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Persons are considered to have limited English proficiency if they indicated that they spoke a language other than English, and if they spoke English less than "very well". Persons are considered to live in linguistically isolated households if no one aged 14 and over in the households speaks English only or speaks a language other than English at home and speaks English “very well” Area demographic statistics are measured as a percentage of the total population aged 5 based on the following formula:

\[
\text{Percentage} = \frac{\text{Linguistically Isolated Population}}{\text{Total Population in Households}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

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. 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.

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 with Limited English Proficiency

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/acs/www/) website.

**Methodology**

Population counts for population by language proficiency 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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Persons are considered to have limited English proficiency if they indicated that they spoke a language other than English, and if they spoke English less than "very well". Area demographic statistics are measured as a percentage of the total population aged 5 based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population Age 5]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete [American Community Survey 2012 Subject Definitions](https://www.census.gov/acs/www/data_documentation/2012/special-tabulations/).  

**Notes**

**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. 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.

**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 2008-2012. Data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population using the following formula:

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

For more information on the specific data elements reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

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. 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.

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).

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 2008-2013. 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 2012 Subject Definitions.

Notes

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. 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.

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).
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 2008-2012. 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 2012 Subject Definitions.

Notes

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. 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.

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).

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](https://www.census.gov) web page.

**Notes**

**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. 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.

**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](https://nces.ed.gov) 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.

Notes

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.

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 2008-2012. 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.

Notes
**Trends Over Time**
The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

**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. 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.

**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.

**Families with Income Over $75,000**

**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.

**High School Graduation Rate (EdFacts)**

**Data Background**
EDFacts is a U. S. Department of Education (ED) initiative to collect, analyze, report on, and promote the use of high-quality, kindergarten through grade 12 (K–12) performance data for use in education planning, policymaking, and management and budget decision-making to improve outcomes for students. EDFacts centralizes data provided by state education agencies, local education agencies, and schools, and provides users with the ability to easily analyze and report on submitted data. ED collects performance data at the school and school-district levels and provides public use files containing data that have been modified to protect against the ability to determine personally identifiable information on students.

Methodology

Graduation rates are acquired for all US school-districts in the United States from US Department of Education (ED) EdFacts data tables. States are required to report graduation data to the US Department of Education under Title I, Part A of the Elementary and Secondary Education Act (ESEA). Specifically, states are required to report rates based on a cohort method, which would provide a more uniform and accurate measure of the high school graduation rate that improved comparability across states. The cohort graduation rate is defined as “the number of students who graduate in four years with a regular high school diploma divided by the number of students who form the adjusted cohort for the graduating class.” From the beginning of 9th grade (or the earliest high school grade), students who are entering that grade for the first time form a cohort that is “adjusted” by adding any students who subsequently transfer into the cohort and subtracting any students who subsequently transfer out, emigrate to another country, or die.

County-level summaries are calculated by CARES using small-area estimation technique based on the proportion of the population aged 15-19 in each school district/county. The population figures for this calculation are based on data from the 2010 US Decennial Census at the census block geographic level.

For more information please consult the original data the original data or download the complete EdFacts Data Documentation.

Notes

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

Data Limitations
1. Graduation rates for some school districts are provided by EdFacts as ranges; range mid-points were calculated by CARES to facilitate data manipulation.
2. Data is not currently available for three states - Idaho, Kentucky, and Oklahoma - due to incomplete student cohort data for the four years prior to 2011.

High School Graduation Rate (NCES)

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

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

Notes

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.

Households Receiving Public Assistance Income

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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Public assistance income provides cash payments to poor families and includes General Assistance and Temporary Assistance to Needy Families (TANF), which replaced Aid to Families with Dependent Children (AFDC) in 1997. Public assistance income does not include Supplemental Security Income (SSI), noncash benefits such as Food Stamps/SNAP, or separate payments received for hospital or other medical care. Area demographic statistics are measured as a percentage of the total population based on 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 2012 Subject Definitions.

Notes

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. 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.

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.
Income Per Capita

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

Total income 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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Per capita income is the mean money income received in the past 12 months computed for every man, woman, and child in a geographic area. It is derived by dividing the total income of all people 15 years old and over in a geographic area by the total population in that area based on the following formula:

\[
\text{Per Capita Income} = \frac{[\text{Total Income of Population Age 15}]}{[\text{Total Population}]}
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

Trends Over Time

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

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. 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.

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.

Index of Disparity (ID)
The Index of Disparity (ID) used with this indicator was adopted by researchers at the National Center for Health Statistics (NCHS) and the National Institute of Health (NIH) for use with Healthy People 2010 and 2020 guidelines. This index measures the magnitude of variation in indicator percentages across groups - in this case racial and ethnic groups. Specifically, the index of disparity is defined as “the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage”. The ID values for the indicator displayed here are calculated from American Community Survey 2008-12 5-year estimates using the following four population subgroups: Non-Hispanic White; Hispanic or Latino; Black or African American; and Other Race. The Other Race category includes Asian, Native American / Alaskan Native, Native Hawaiian / Pacific Islander, Multiple Race, and Some Other Race populations.

The ID can be expressed using the following formula:

Index of Disparity = 100.0 * ( ( SUM ( |r - R| ) / n) / R )

...where r is the sub-group rate and R is the total population rate. Index values range from 0 (where all sub-groups are equal) to infinity. Index values are heavily dependent on the total population value ( R ), so comparisons should be made across geographic areas (county vs. state vs. nation), and not across indicators.

For more information on the index of disparity, please see the NIH research article A Summary Measure of Health Disparity.

Lack of 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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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) 2007-2011 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.

**Notes**

**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 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](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 2008-2012. 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).  

**Notes**

**Trends Over Time**

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

**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. 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.

**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.

_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 2008-2012. 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](#).

**Notes**

**Trends Over Time**

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

**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. 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.

**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.

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 5 year period 2008-2012. Data are aggregate summaries based on 2010 Census Tract 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 universe 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 2012 Subject Definitions.

Notes

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. 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.

Data Limitations
The population 'universe' for most health insurance coverage estimates is the civilian noninstitutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Some noninstitutionalized 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 noninstitutionalized 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 noninstitutionalized population, the distributions in the published tables may differ slightly from how they would look if the total population were represented.

Population Receiving SNAP Benefits (ACS)

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 household program participation and total household data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2008-2012. Mapped data are summarized to 2010 census tract boundaries. This indicator is a measure of household-level SNAP participation based on survey response about "receipts of food stamps or a food stamp benefit card in the past 12 months" by one or more household members. Area statistics are measured as a percentage of total occupied households based on the following formula:

Percentage = [Participating Households] / [Total Households] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.
Notes

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. 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.

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 population by educational attainment 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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population aged 25 based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population Age 25]}} \times 100
\]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

Trends Over Time
The American Community Survey multi-year estimates are based on data collected over 5 years. For
any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

**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. 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.

**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](https://www.census.gov) website.

**Methodology**
Population counts for population by educational attainment 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 2008-2012. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population aged 25 based on the following formula:

\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population Age 25]}} \times 100
\]
For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2012 Subject Definitions.

Notes

Trends Over Time
The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

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. 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.

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 Indicator Warehouse.

Methodology
Counts for this indicator represent the annual average births over the 5-year period 2007-2011. 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:

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

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.

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. In their original form, birth statistics from the CDC National Vital Statistics System (NVSS) are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Birth data from the Health Indicators Warehouse is provided using combined race/ethnicity. Due to sample size, data for this indicator is only reported for White (Non-Hispanic), Black (Non-Hispanic), Other (Non-Hispanic) and the Hispanic or Latino population.

Data Suppression
Suppression is used to protect confidentiality and to avoid misinterpretation when rates are unstable. Data is suppressed for all indicator components (geographic area population group) with fewer than 20 births over the report period.

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 modelled 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 sub-state 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:

\[
\text{Unemployment Rate} = \frac{\text{[Total Unemployed]}}{\text{[Total Labor Force]}} \times 100
\]

For more information, please visit the Bureau of Labor Statistics Local Area Unemployment Statistics web page.
Notes

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. The models predict state and 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 modelled 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.

Notes

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the US Census Bureau’s Small Area Health Insurance Estimates (SAHIE) program is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available 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. The models predict state and 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:

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

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.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the US Census Bureau's Small Area Health Insurance Estimates (SAHIE) program is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available 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 5 year period 2008-2012. Data are aggregate summaries based on 2010 Census Tract 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 universe 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 2012 Subject Definitions.

Notes

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. 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.

Data Limitations

The population “universe” for most health insurance coverage estimates is the civilian noninstitutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Some noninstitutionalized 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 noninstitutionalized 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 noninstitutionalized population, the distributions in the published tables may differ slightly from how they would look if the total population were represented.

**Violent Crime**

**Data Background**

The Federal Bureau of Investigation (FBI) is a governmental agency belonging to the United States Department of Justice that serves to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies and partners.

**Methodology**

Violent crimes and rates are reported for each police jurisdiction and consist of homicide, forcible rape, robbery, and aggravated assault. Population figures are estimates for July 2012 acquired from the US Census Bureau’s Population Estimates program. Rates are reported as the number of crimes per 100,000 population using the following formula:

\[
\text{Crime Rate} = \frac{\text{[Number Violent Crimes]}}{\text{[Total Population]}} \times 100,000
\]

*Police jurisdictions may be defined by the boundary of a county, county subdivision, or city. Regional police departments may consist of multiple cities or subdivisions.

Access to the complete methodology, including quality assurance procedures and sample crime reporting forms, is available at the Federal Bureau of Investigations [Uniform Crime Reports](https://www.fbi.gov) website.

**Notes**

**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 Limitations**

1. Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data and maps do not necessarily represent an exhaustive list of crimes due to gaps in reporting.
2. Data for forcible rape was not consistently reported by city and county agencies in the state of Minnesota. Forcible rapes are not included in the violent crime summaries for cities and counties in that state.
3. Some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds. These offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports [Universities and Colleges](https://www.fbi.gov) data tables.

**Data Suppression**

Suppression is used to avoid misinterpretation when rates are unreliable or unstable. When the FBI determines that an agency’s data collection methodology does not comply with national UCR guidelines, the figure(s) for that agency’s offense(s) are not be included. For further details please see the original data tables available online through the FBI [Crime in the US](https://www.fbi.gov) website.

**Air Quality - Ozone**

146
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** = \[ \frac{\text{SUM} \left[ \text{Concentration} \right]}{365} \]

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

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](http://www.epa.gov) resource page.

Notes

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** = \[ \frac{\text{SUM} \left[ \text{Concentration} \right]}{365} \]

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

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](http://www.epa.gov) resource page.

Notes
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.

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 website.

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 data file. Industries are stratified based on the 2012 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 NAICS codes used to identify establishment categories within the County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110
  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.
- Fast food restaurants: 722513 (formerly 722211)
  Any “limited service” establishments where the customer typically orders or selects items and pay
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.

Notes

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.

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:
1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3) Rates do not describe quality of the establishment or utilization frequency.

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 website.

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 data file. Industries are stratified based on the 2012 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 NAICS codes used to identify establishment categories within the County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110
  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.

- Fast food restaurants: 722513 (formerly 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.

Notes
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.

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:
1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3) Rates do not describe quality of the establishment or utilization frequency.

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 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 website.

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 data file. Industries are stratified based on the 2012 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 NAICS codes used to identify establishment categories within the County Business Patterns (CBP) are listed below.

- **Grocery stores and supermarkets:** 445110
  
  *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.*

- **Fast food restaurants:** 722513 (formerly 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](#).

**Notes**

**Race and Ethnicity**

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

**Data Limitations**

Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:

1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.

2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.

3) Rates do not describe quality of the establishment or utilization frequency.

**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 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.

Notes

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.

Modified Retail Food Environment Index

Data Background
The Division of Nutrition, Physical Activity, and Obesity (DNPAO) is a program run by the Centers for Disease Control and Prevention (CDC), a division of the US Department of Health & Human Services. The agency utilizes a public health approach to address the role of nutrition and physical activity in improving the public's health and preventing and controlling chronic diseases. The DNPAO published the Modified Retail Food Environmental Index (MRFEI) for each state in the US in 2011. The MRFEI is a measure of the proportion of food retailers that sell healthy foods compared to retailers that sell unhealthy foods. Scores can range from 0 (no food retailers that typically sell healthy food) to 100 (only food retailers that typically sell healthy food). Areas with lower MRFEI scores have more food retailers (like fast food restaurants and convenience stores) that are less likely to sell less healthy foods and fewer food retailers (like supermarkets) that tend to sell healthy foods such as fresh fruits and vegetables.

Methodology
Census tract-level Modified Retail Food Environmental Index (mRFEI) data was acquired from the CDC Division of Nutrition, Physical Activity, and Obesity (DNPAO). This dataset contains index values for each census tract (using census 2000 boundaries) based on the proportion of healthy to unhealthy food retailers located in the tract. mRFEI scores were classified into different healthy food access categories as follows:

- Under 0.0  No Food Outlet
- 0.0        No Healthy Food Outlet
- 0.1 – 5.0  Poor Healthy Food Access
- 5.1 – 15.0 Low Healthy Food Access
- 15.1 – 30.0 Moderate Healthy Food Access
- Over 30.0  High Healthy Food Access

The number of persons living in tracts with each food access designation was calculated using Census 2000 population figures and summarized to the county or state level. Percentages were generated by dividing these figures by the total population in each county or state. For more information, please see the complete CDC Modified Retail Food Environment Index Report.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories the US Census Bureau 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 Decennial Census are: White, Black, American Indian/Alaskan Native, Asian, and Other. A census 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 Decennial Census Summary File 1 by combined race and ethnicity. Indicator race and ethnicity statistics (total and percentages) are generated using the method described above. Totals and percentages are only available by race and ethnicity for populations in tracts with low, poor, or no healthy food access (tracts with scores under 15.1).
Index of Disparity (ID)

The Index of Disparity (ID) used with this indicator was adopted by researchers at the National Center for Health Statistics (NCHS) and the National Institute of Health (NIH) for use with Healthy People 2010 and 2020 guidelines. This index measures the magnitude of variation in indicator percentages across groups - in this case racial and ethnic groups. Specifically, the index of disparity is defined as "the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage". The ID can be expressed using the following formula:

\[
\text{Index of Disparity} = 100.0 \times \left( \frac{\text{SUM}(|r - R|)}{n \times R} \right)
\]

...where \( r \) is the sub-group rate and \( R \) is the total population rate. Index values range from 0 (where all sub-groups are equal) to infinity. Index values are heavily dependent on the total population value (\( R \)), so comparisons should be made across geographic areas (county vs. state vs. nation), and not across indicators.

For more information on the index of disparity, please see the NIH research article *A Summary Measure of Health Disparity*.

Park Access

Data Background

ESRI's ArcGIS map gallery provides a platform for viewing and downloading various public-use datasets. OpenStreetMap (OSM) is a collaborative project to create a free editable map of the world. OSM components are available for download in bulk through the third party platforms, including the WeoGeo market.

Methodology

The percentage and number of people living within 0.5 miles of the boundary of a park was calculated by CARES. The population living within a 0.5 mile radius of any park boundary (buffer) was determined at the census block level using 2010 census block centroids. These figures were aggregated to census tract, county, and state levels. These estimates use population figures from the US Census Bureau 2010 Decennial Census. Park boundaries are acquired from a combination of sources, including ESRI's USA Parks (2010), as well as OpenStreetMap (2013). Land feature types from these layers include: local parks, state parks and forests, national parks and forests, national monuments, and beaches. OpenStreetMap park features include some nature preserves, skate parks, and dog parks.

Notes

**Data Limitations**
1. Navteq parks data includes local, state, and national park as well as national forests. These locations may represent a wide spectrum of infrastructure that encourages physical activity, and not all locations may present equal opportunities.
2. This indicator may overestimate park access since routes to park entrances may be much farther than a direct line from a residence to a park boundary.
3. The data may not capture places that serve park functions, but are not classified as parks, such as an unofficial trail along a utility corridor, or a school-yard open for public use under a joint use agreement.
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.

Notes

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 website.

**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 data file. Industries are stratified based on the 2012 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 NAICS codes used to identify establishment categories within the County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110
  
  *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.*

- Fast food restaurants: 722513 (formerly 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.

**Notes**
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.

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:
1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3) Rates do not describe quality of the establishment or utilization frequency.

SNAP-Authorized Food Store Access

Data Background
The Food and Nutrition Service (FNS) is an agency of USDA’s Food, Nutrition, and Consumer Services. FNS works to end hunger and obesity through the administration of 15 federal nutrition assistance programs including WIC, Supplemental Nutrition Assistance Program (SNAP), and school meals. In partnership with State and Tribal governments, FNS' programs serve one in four Americans during the course of a year. The FNS mission is to increase food security and reduce hunger by providing children and low-income people access to food, a healthful diet and nutrition education in a way that supports American agriculture and inspires public confidence.

Methodology
Locations of SNAP-Authorized retailers was acquired from the US Department of Agriculture (USDA) Food and Nutrition Service (FNS) SNAP Retailers Locator. This data was processed and each retailer was assigned to the census tract which it fell entirely within. Counts of retailers per each census tract were generated. SNAP-retailer access rates were then calculated for each tract based on the number of stores per 10,000 population.

Locations of SNAP-authorized retailers are compiled by the USDA’s Food and Nutrition Service, SNAP Benefits Redemption Division. This data is updated periodically and was last current as of July 16, 2013. Population data are from the U.S. Census Bureau. Indicator data is presented as a rate per 10,000 population based on the following formula:

\[
\text{Rate} = \frac{\text{[SNAP-Authorized Retailers]}}{\text{[Total Population]}} \times 10,000
\]

For more information, please refer to the SNAP Retailer Locator documentation.

Notes
**Data Limitations**
Reported data represent summaries limited by census tract boundaries. When comparing rates, consider the following:

1) Rates assume uniform distribution of both establishments and populations throughout the tract and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent tract rates when populations or establishments are highly concentrated near tract borders.
3) Rates do not describe quality of the establishment or utilization frequency.

**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](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 2008-2012. 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 2012 Subject Definitions](https://www.census.gov).

**Notes**

**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. 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.

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:

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

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

Notes

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

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:

1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3) Rates do not describe quality of the establishment or utilization frequency.

Access to Primary Care

Data Background
The Area Health Resource File (AHRF) 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 AHRF 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 Health Resource File website.

Methodology

Physician data are acquired from the 2012-13 Health Resources and Services Administration (HRSA) Area Health Resource File (AHRF). These counts are tabulations from the 2011 American Medical Association (AMA) Physician Masterfiles. Doctors classified as “primary care physicians” by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing subspecialties within the listed specialties are excluded. Population data for this indicator are also acquired from the AHRF, and are based on U.S. Census Bureau 2011 Population Estimates.

Data is tabulated for physicians practicing patient care only. Patient care practitioners include office-based physicians, hospital residents (including clinical fellows), and hospital-based (FT) staff. Non-patient care practitioners include administrators, medical teachers, researchers, etc. Rates are calculated per 100,000 total population using the following formula:

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

For detailed documentation or to view the original data, please view the documentation included in the 2012-2013 AHRF, which can be downloaded here.

Notes

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

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:
1) Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2) Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3) Rates do not describe quality of the establishment or utilization frequency.

Cancer Screening - Mammogram

161
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.

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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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) 2007-2011 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.

Notes

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.

Cancer Screening - Sigmoidoscopy or 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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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) 2007-2011 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.

Notes

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

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."
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.

**Notes**

**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 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.

Notes

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

Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. 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 from September 2013. FQHC addresses were geocoded using the ESRI ArcGIS Online 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.

Notes

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:

$$\text{Adults Not Taking Blood Pressure Medication} = \left(\frac{\text{Indicator Percentage}}{100}\right) \times \text{[Total Adult Population]}$$

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.

Notes

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 2011-2012. 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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 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 2011-2012. 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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 Prenatal Care

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 4-year period 2007-2010. Original data was tabulated by the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) based on information reported on each birth certificate. Rates represent the number of births to mothers with no prenatal care, or prenatal care beginning after the first trimester. Rates are summarized based on the following formula

\[
\text{Rate} = \frac{\text{[Late or No Prenatal Care Births]}}{\text{[Total Births]}} \times 100
\]

Data was acquired from the CDC WONDER database. For more information about this source, including data suppression information, please visit the CDC WONDER Current Natality data page, or refer to the NVSS natality public use file documentation.

Notes

Data Suppression

Suppression is used to protect confidentiality and to avoid misinterpretation when rates are unstable. Data is suppressed for all counties with fewer than 100,000 total population.

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.

Pneumonia Vaccination

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.”
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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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) 2007-2011 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.

Notes

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's full time equivalency* 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:

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

* Total equivalency population:

HPSA Designation populations may exceed total census populations in areas with large transient populations as follows:

- Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 2 to 8 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.
- Other tourists (non-resident) may be included in an area's population but only with a weight of 0.25, using the following formula: Effective tourist contribution to population = 0.25 x (fraction of year tourists are present in area) x (average daily number of tourists during portion of year that tourists are present).
- Migratory workers and their families may be included in an area's population, using the following formula: Effective migrant contribution to population = (fraction of year migrants are present in area) x (average daily number of migrants during portion of year that migrants are present)

For additional information, including designation procedures and access to the original data, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

Notes
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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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) 2007-2011 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.

Notes

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, SiteReports 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 SiteReports 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 SiteReports website.

Methodology

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Tract-level and county-level expenditure estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain state and national ranks for counties, and percent expenditure estimates based on aggregated tract-level data. The percent expenditure figures calculated for custom geographic areas can be expressed using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{[Category Expenditures]}}{\text{[Total Area Expenditures]}} \times 100
\]

To generate acceptable county-level output for indicator report pages, percent expenditures for each food-at-home category were sorted and ranked by county. Each county’s within-state rank and that rank’s percentile are displayed in the indicator data table. This information is not available for custom geographic areas, for states, or for the total United States. County percentiles are calculated using the following formula:

\[
\text{Percentile} = \frac{\text{[County Within State Rank]}}{\text{[Total Number of Counties in State]}} \times 100
\]

To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract 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.

Notes
**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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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) 2005-2009 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.

**Notes**

**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, SiteReports 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 SiteReports 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 SiteReports website.

Methodology

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Tract-level and county-level expenditure estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain state and national ranks for counties, and percent expenditure estimates based on aggregated tract-level data. The percent expenditure figures calculated for custom geographic areas can be expressed using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{Category Expenditures}}{\text{Total Area Expenditures}} \times 100
\]

To generate acceptable county-level output for indicator report pages, percent expenditures for each food-at-home category were sorted and ranked by county. Each county’s within-state rank and that rank’s percentile are displayed in the indicator data table. This information is not available for custom geographic areas, for states, or for the total United States. County percentiles are calculated using the following formula:

\[
\text{Percentile} = \frac{\text{County Within State Rank}}{\text{Total Number of Counties in State}} \times 100
\]
To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract 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](#).

**Notes**

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

**Physical Inactivity**

**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:

\[
\text{Percent Prevalence} = \frac{\text{[Risk Factor Population]}}{\text{[Total Population]}} \times 100.
\]

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.

Notes

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, SiteReports 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 SiteReports 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 SiteReports website.

Methodology

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Tract-level and county-level expenditure estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain state and national ranks for counties, and percent expenditure estimates based on aggregated tract-level data. The percent expenditure figures calculated for custom geographic areas can be expressed using the following formula:

\[
\text{Percent Expenditures} = \frac{[\text{Category Expenditures}]}{[\text{Total Area Expenditures}]} \times 100
\]

To generate acceptable county-level output for indicator report pages, percent expenditures for each food-at-home category were sorted and ranked by county. Each county’s within-state rank and that rank’s percentile are displayed in the indicator data table. This information is not available for custom geographic areas, for states, or for the total United States. County percentiles are calculated using the following formula:

\[
\text{Percentile} = \frac{[\text{County Within State Rank}]}{[\text{Total Number of Counties in State}]} \times 100
\]

To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract 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.

Notes

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

Data Background

Nielsen is a publicly 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, SiteReports 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 SiteReports 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 SiteReports website.

Methodology

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Tract-level and county-level expenditure estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain state and national ranks for counties, and percent expenditure estimates based on aggregated tract-level data. The percent expenditure figures calculated for custom geographic areas can be expressed using the following formula:

\[
\text{Percent Expenditures} = \frac{[\text{Category Expenditures}]}{[\text{Total Area Expenditures}]} \times 100
\]

To generate acceptable county-level output for indicator report pages, percent expenditures for each food-at-home category were sorted and ranked by county. Each county's within-state rank and that rank's percentile are displayed in the indicator data table. This information is not available for custom geographic areas, for states, or for the total United States. County percentiles are calculated using the following formula:

\[
\text{Percentile} = \frac{[\text{County Within State Rank}]}{[\text{Total Number of Counties in State}]} \times 100
\]

To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract 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](#).

**Notes**

**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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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
numerator (number of adult smokers) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[ \text{[Adults Smokers]} = \left( \frac{\text{[Indicator Percentage]}}{100} \right) \times \text{[Total Population]} . \]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2007-2011 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.

Notes

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 2011-2012. Percentages are generated based on valid responses to the following questions:

"Have you smoked at least 100 cigarettes in your entire life?" 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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 home page.

Methodology

Indicator percentages are acquired from analysis of annual survey data from the Behavioral Risk Factor Surveillance System (BRFSS) for years 2011-2012. Percentages are generated based on valid
responses to the following questions:

"During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?"

Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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.

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 2011-2012. 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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.

Cancer Incidence - Breast

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 2006-2010 from the State Cancer Profiles: Incidence Rates data tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2000 US standard population. The new case counts (incidence) 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. The population data displayed in the report summary tables are based on American Community Survey 2006-10 5-year estimates and are shown for reference only.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

\[
\text{Adj. Population} = \left( \frac{\text{[Cancer Incidence]}}{\left(\frac{\text{[Adj. Incidence Rate]}}{100,000}\right)} \right)
\]

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

\[
\text{Adj. Incidence Rate} = 100,000 \times \left( \frac{\text{[Cancer Incidence]}}{\text{[Adj. Population]}} \right)
\]

For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations
1. Data is not available for the state of Kansas because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data is not available for the state of Minnesota.
3. Data for Ohio counties are acquired from CDC WONDER. Data are estimates based on metropolitan areas which consist of multiple counties.
4. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

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, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000

Cancer Incidence - Cervical

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 2006-2010 from the State Cancer Profiles: Incidence Rates data tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2000 US standard population. The new case counts (incidence) 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. The population data displayed in the report summary tables are based on American Community Survey 2006-10 5-year estimates and are shown for reference only.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

\[
\text{Adj. Population} = \left( \frac{\text{Cancer Incidence}}{\left( \frac{\text{Adj. Incidence Rate}}{100,000} \right)} \right)
\]

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

\[
\text{Adj. Incidence Rate} = 100,000 \times \left( \frac{\text{Cancer Incidence}}{\text{Adj. Population}} \right)
\]

For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations

1. Data is not available for the state of Kansas because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data is not available for the state of Minnesota.
3. Data for Ohio counties are acquired from CDC WONDER. Data are estimates based on metropolitan areas which consist of multiple counties.
4. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

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, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000.

Cancer Incidence - Colon and Rectum

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 2006-2010 from the State Cancer Profiles: Incidence Rates data tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2000 US standard population. The new case counts (incidence) 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. The population data displayed in the report summary tables are based on American Community Survey 2006-10 5-year estimates and are shown for reference only.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

\[
\text{Adj. Population} = \left( \frac{\text{Cancer Incidence}}{\left( \frac{\text{Adj. Incidence Rate}}{100,000} \right)} \right)
\]

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

\[
\text{Adj. Incidence Rate} = 100,000 \times \left( \frac{\text{Cancer Incidence}}{\text{Adj. Population}} \right)
\]
For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations
1. Data is not available for the state of Kansas because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data is not available for the state of Minnesota.
3. Data for Ohio counties are acquired from CDC WONDER. Data are estimates based on metropolitan areas which consist of multiple counties.
4. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

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, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000.

Cancer Incidence - Lung

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 2006-2010 from the State Cancer Profiles: Incidence Rates data tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2000 US standard population. The new case counts (incidence) 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. The population data displayed in the report summary tables are based on American Community Survey 2006-10 5-year estimates and are shown for reference only.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

\[
\text{Adj. Population} = \left( \frac{\text{[Cancer Incidence]}}{\left( \frac{\text{[Adj. Incidence Rate]}}{100,000} \right)} \right)
\]

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

\[
\text{Adj. Incidence Rate} = 100,000 \times \left( \frac{\text{[Cancer Incidence]}}{\text{[Adj. Population]}} \right)
\]

For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations
1. Data is not available for the state of Kansas because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data is not available for the state of Minnesota.
3. Data for Ohio counties are acquired from CDC WONDER. Data are estimates based on metropolitan areas which consist of multiple counties.
4. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

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, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000.

Cancer Incidence - Prostate

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 2006-2010 from the State Cancer Profiles: Incidence Rates data tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2000 US standard population. The new case counts (incidence) 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. The population data displayed in the report summary tables are based on American Community Survey 2006-10 5-year estimates and are shown for reference only.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

\[
\text{Adj. Population} = \left( \frac{\text{Cancer Incidence}}{\left( \frac{\text{Adj. Incidence Rate}}{100,000} \right)} \right)
\]

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

\[
\text{Adj. Incidence Rate} = 100,000 \times \left( \frac{\text{Cancer Incidence}}{\text{Adj. Population}} \right)
\]

For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations
1. Data is not available for the state of Kansas because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data is not available for the state of Minnesota.
3. Data for Ohio counties are acquired from CDC WONDER. Data are estimates based on metropolitan areas which consist of multiple counties.
4. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

**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, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000.

**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.

**Notes**

**Race and Ethnicity**

Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data.
summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

Diabetes (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:

\[
\text{Percent Prevalence} = \frac{\text{[Risk Factor Population]}}{\text{[Total Population]}} \times 100.
\]

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.
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.

Notes

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.

Diabetes (Medicare Population)

Data Background
The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. CMS provides various data on the Medicare population based on claims and enrollment data.

Methodology
Indicator percentages are acquired for 2012 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

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 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.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

Heart Disease (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 2011-2012. 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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.

Heart Disease (Medicare Population)

Data Background
The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. CMS provides various data on the Medicare population based on claims and enrollment data.

Methodology
Indicator percentages are acquired for 2012 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

High Cholesterol (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.

High Cholesterol (Medicare Population)

Data Background

The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. CMS provides various data on the Medicare population based on claims and enrollment data.

Methodology

Indicator percentages are acquired for 2012 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

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 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.

Notes

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

Infant Mortality

Data Background

The Area Health Resource File (AHRF) 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 AHRF 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 Health Resource File website.

Methodology

Total births and infant mortality rates are 5-year averages acquired from the 2012 Health Resources and Services Administration (HRSA) Area Resource File (ARF). Total infant deaths are back-calculated based on these figures. Mortality rates represent the number of deaths to infants under age 1 per 1,000 total live births, based on the following formula:

\[
\text{Rate} = \frac{\text{Total Deaths Under Age 1}}{\text{Total Births}} \times 1,000
\]
The ARF documentation states the following about the infant mortality data:

The NCHS Mortality Data were obtained from the National Center for Health Statistics Detail Mortality data files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. The number of infant deaths for a county are based on place of residence; non residents of the US are excluded. Averages are provided rather than actual data for each year because of data use restrictions required by NCHS beginning with 1989 data.

For additional information, please review the documentation for the HRSA ARF, available for download here.

Notes

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC is available by combined race and ethnicity, and is reported here only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator due to sample size limitations. Detailed race/ethnicity data may be available from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when there are fewer than 10 cases in the numerator (for each county / population group combination) over the report period.

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.

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.

Mortality - Cancer

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:

\[
\text{Mortality Rate} = \left[ \frac{\text{SUM(Total Population)} \times ((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} \right] \times 100,000.
\]

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00–I09, I11, I13, I20–I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

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.

Mortality - Heart Disease

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00–I09, I11, I13, I20–I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86
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.

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.

Mortality - 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:

Mortality Rate = [SUM(Total Population) * ((Age-Adjusted Rate)/100,000)] / [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 (ischaemic) heart disease:I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00–I09, I11, I13, I20–I51
Intentional self-harm (suicide): X60-X84, Y870
Malignant neoplasm (cancer): C00-C97
Motor vehicle accident: V01-V79
Unintentional injury (accident): V01-X59, Y85-Y86

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.

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.

Mortality - Ischaemic Heart Disease

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

**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.

**Mortality - Lung Disease**

**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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

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.

Mortality - Motor Vehicle Accident

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:
Mortality Rate = \[\text{SUM(Total Population)} \times \frac{((\text{Age-Adjusted Rate})/100,000)}{\text{SUM(Total Population)}} \times 100,000.\]

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00–I09, I11, I13, I20–I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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 database 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.

Mortality - Pedestrian Accident

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 excellene 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](#).

**Mortality - Premature Death**

**Data Background**

The County Health Rankings (CHR) is a data service of the [University of Wisconsin Population Health Institute](#) 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 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](#) (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:

\[ \text{YPLL} = \left[ 75 \times (\text{Number of Deaths Under Age 75}) \right] - \left[ \text{SUM (Age at Death)} \right] \]

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](#) indicator information.

**Notes**

**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.

**Mortality - Stroke**

**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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00–I09, I11, I13, I20–I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

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.

Mortality - 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:

\[
\text{Mortality Rate} = \frac{\text{SUM(Total Population)} \times \frac{\text{(Age-Adjusted Rate)}}{100,000}}{\text{SUM(Total Population)}} \times 100,000.
\]

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

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.
Mortality - Unintentional Injury

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:

\[
\text{Mortality Rate} = \frac{\text{SUM}(\text{Total Population}) \times (\text{Age-Adjusted Rate}/100,000)}{\text{SUM}(\text{Total Population})} \times 100,000.
\]

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 (ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease: J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): X60-X84, Y870
- Malignant neoplasm (cancer): C00-C97
- Motor vehicle accident: V01-V79
- Unintentional injury (accident): V01-X59, Y85-Y86

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.

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

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:

\[
\text{Percent Prevalence} = \frac{\text{[Risk Factor Population]}}{\text{[Total Population]}} \times 100.
\]

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.

**Notes**

**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**

**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 2011-2012. 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 using the methods described in the BRFSS Comparability of Data documentation.

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.

Notes

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 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)."

215
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:

\[
\text{Adults Poor Dental Health} = \left( \frac{[\text{Indicator Percentage}]}{100} \right) \times [\text{Total Population}].
\]

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 BRFSS web site.

**Notes**

**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 and tabulated into county estimates by the BRFSS analysis team. 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 housed 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 2006-2012 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:

"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:

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

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2007-2011 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.

**Notes**

**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 2008-2012. 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 universe (non-institutionalized) 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 2012 Subject Definitions.

Notes

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. 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.

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).

© Community Commons & IP3.