Community Health Needs Assessment and Implementation Plan

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Memorial Hospital
North Conway, NH

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OVERVIEW: 2013 Community Health Needs Assessment

An assessment of the Mt. Washington Valley towns in Carroll County, NH and Oxford County, ME conducted jointly by Memorial Hospital and the participants of the White Mountain Valley Community Health Council (formerly known as the MWV Community Healthcare Collaborative)

Provisions in the federal Affordable Care Act require charitable hospitals to conduct community health needs assessments and adopt implementation strategies to meet needs identified through their community health needs assessment (CHNA).

During the first half of 2013, such an assessment was conducted by Memorial Hospital in North Conway in collaboration with members of the White Mountain Valley Community Health Council (WMVCHC) for the 35,000 residents of central and northern Carroll County and several border towns in western Maine. This locale is generally known as the Mt. Washington Valley, a 900-square-mile predominantly rural area that includes significant portions of the White Mountain National Forest. The town of Conway is considered the primary economic center for working, shopping and healthcare services, while each town and village has its own unique history and attributes.

In 2010, Memorial Hospital and most of the current members of the WMVCHC were part of an extensive Community Health Needs Assessment process that included collection of quantitative and qualitative public health data, a community health survey, and distribution of the assessment results. Since that time, the group has created and implemented several strategies to address issues identified during that process. Part of this current evaluation includes a look-back at the key health issues from 2010 and a summary of the programs that have since been developed and achieved success. Moving forward, the group intends to build on this foundation by identifying priority needs from 2010 that still exist as well as any new issues uncovered by the assessment.

Assessment data for the 2013 CHNA was collected utilizing the Community Health Needs Assessment Toolkit, a web-based platform designed by Community Commons, and recommended by the Centers for Disease Control & Prevention, Office of the Associate Director of Policy. The toolkit assists hospitals and organizations to better understand the needs and assets of their communities, and to collaborate more effectively in making measurable community health improvements.¹ In addition to the collection of secondary data, input was documented from the WMVCHC members and agencies, the Patient Advisory Council at Memorial Hospital, and the executive director of the Carroll County Public Health Coalition.

The combined results of the 2010 and 2013 CHNAs will be used by the WMVCHC to assess priority issues and develop strategies for the group’s ongoing future activities. Memorial Hospital will identify the specific strategies for which it will serve as primary leader as part of its implementation plan and the methods that will be used to evaluate the effectiveness of any interventions.

¹ [www.assessment.communitycommons.org/CHNA](http://www.assessment.communitycommons.org/CHNA)
The WMVCHC and Memorial will actively communicate the key results of the CHNA to the community by way of sharing with their internal stakeholders, and distributing summaries of the information through media and online websites. The assessment was developed and is owned jointly by the WMVCHC partners, including Memorial Hospital. It was managed and documented by Sharon Malenfant, MS, APR, who holds a Master’s in Health Policy and Management and has more than 20 years of experience in the community health field.

The implementation strategies also will be developed collaboratively, but the hospital and each lead agency is responsible for carrying out its own implementation plan. The hospital will include its plan with the filing of its IRS Form 990, Schedule H. The hospital and other members of WMVCHC who are required by New Hampshire law to file annual Community Benefit Reports will do so by relying on this assessment and their individual corresponding implementation plans.

**NOTE:** It is important to point out that the available public health data referenced in this report is limited by several factors which suggest caution in interpretation. At most, the data is available only at the county level which generally exceeds the service area of Memorial Hospital and other partners in this process. A few occurrences in a small population from one year to the next can skewer results and create the appearance of a significant problem where none really exists. This underscores the importance of input from community stakeholders and their representatives, as well as from the participating agencies in this process. Their opinions, expertise and knowledge of the day-to-day needs encountered by the population they serve are critical components in identifying and prioritizing the most important health issues in this community.

### Looking Back: The 2010 Community Health Needs Assessment

By reviewing earlier data and findings, it is possible to evaluate the continuing impact of identified trends and any potential changes that may have resulted from planned or unanticipated interventions. During the 2010 Community Health Needs Assessment, the local group found several key health issues through the secondary data that was collected from a variety of public health sources. The indicators in which the Mt. Washington Valley differed significantly from the rest of the state included the following:

- The percent of population age 65 and older
- The percent of population who are uninsured or under-insured
- The percent of adults who lack of dental care
- The percent of children and uninsured adults who lack mental health care services
- Incidence of prostate cancer
- ACS Chronic Inpatient Discharges for those age 65+
- ED visits for respiratory system (all ages), asthma (ages 5-14), heart disease (ages 65+), mental health conditions (ages 5-24)
• Inpatient admissions for mental health conditions (ages 5-24); substance abuse mental health conditions (ages 65+)

The group used a widely distributed Community Health Needs Survey to assist it in identifying barriers to care, areas that needed local attention for community health improvement, and priorities for the allocation of resources. However, the collaborative also recognized that some of the major issues affecting the resident population were beyond its means to significantly change or impact.

1. BARRIERS TO CARE: Included the cost of health care services, health insurance, and prescription drugs; geographic barriers such as the location of services; and the lack of easily available medical specialists/services.

2. AREAS NEEDING COMMUNITY ATTENTION:
   • Aging and chronic disease services
   • Alcohol and drug use (Youth and adult)
   • Obesity (Youth and adult)
   • Community health programs
   • Senior housing/assisted living
   • Alzheimer’s services and supports

3. DISEASE PRIORITIES FOR LOCAL RESOURCE ALLOCATION: Cancer, heart disease, diabetes, aging and chronic illnesses.

Actions in Response to 2010 Identified Needs

As a result of the findings of the 2010 Community Health Needs Assessment, Memorial Hospital alone and/or in collaboration with others including the WMVCHC members, developed strategies and implemented plans to address identified health needs. Following is a brief summary of those activities.

PRIORITY HEALTH ISSUES:

1. AGING POPULATION/CHRONIC DISEASE/MEDICAL SPECIALISTS/COMMUNITY HEALTH PROGRAMS/OBESITY/ALZHEIMER’S SUPPORTS & SERVICES/HEART DISEASE/DIABETES

Memorial Hospital has added services and providers that specifically target the needs of the aging population, both those who are healthy and those who have one or more chronic illnesses. This includes the addition or expansion of pulmonology care and rehabilitation, cardiac rehabilitation and ongoing medically supervised exercise, diabetes care and ongoing patient education and support groups, and a wound care/ hyperbaric medicine center.
Memorial Hospital is pursuing membership in the MaineHealth group, an affiliation of hospitals and health care providers in order to improve the community’s access to advanced quality care and a wide range of medical specialties.

Merriman House, Memorial Hospital’s nursing home, provides specialized care for those with Alzheimer’s disease and other memory disorders. They work closely with local providers and agencies to assure appropriate and timely placement that supports people’s opportunity to remain in their own home as long as possible.

Together with Visiting Nurse, Home Care & Hospice of Carroll County (VNHCH), the hospital now offers the community an evidence-based chronic disease self-management program (“Better Choices, Better Health”) developed by Stanford University. They also have collaborated to improve discharge planning and create a continuum of care that reduces the readmission rate for seniors with chronic disease through their “Integrated Chronic Disease Management Program”. Merriman House and VNHCH offer a support group for Caregivers of those with Alzheimer’s and Related Memory Disorders. VNHCH now provides community education through a Loss and Recovery group and Caregivers Self-Help program.

2. UNINSURED POPULATION/COST OF SERVICES/PRESCRIPTION DRUGS/CANCER/ COMMUNITY HEALTH PROGRAMS/DENTAL CARE

Memorial Hospital and its physician practices support the uninsured and under-insured population through their Healthcare Assistance Program. This financial assistance may be used to cover acute, emergency, outpatient and physician charges, as well as amounts due after insurance payments, including deductibles, co-insurance and co-payments.

The hospital supports a Medication Bridge Program which connects those in need with free or reduced cost prescription drugs from pharmaceutical companies; participates in the state’s Breast & Cervical Cancer Program offering free screening services; and secured a Susan G. Komen Foundation grant to implement a Breast Health Patient Navigator Program. This highly effective resource helps women diagnosed with breast cancer obtain the appropriate and necessary care while guiding them through the complexities of the health care system.

The hospital and other health and wellness partners offered a free community health fair with a variety of health screening opportunities free of charge to the public.

In addition, the hospital provides significant annual financial and related support for the White Mountain Community Health Center. The center addresses many of the needs of the medically underserved in the community by providing all services regardless of ability to pay, and offers both free and sliding fee scale appointments. Their healthcare services include primary care, a prenatal program in collaboration with the hospital’s nurse midwives, a teen clinic, family planning services, and a dental program for children.

Utilizing these activities as a basis for improving community health, the hospital and its WMVCHC partners plan to use the 2013 CHNA findings to continue and expand their efforts.
2013 COMMUNITY HEALTH NEEDS ASSESSMENT

(The following CHNA format is derived from “Best Practices for Community Health Needs Assessment and Implementation Strategy Development,” published in February 2012 by the Public Health Institute, and “Assessing & Addressing Community Health Needs,” revised February 2012 by the Catholic Health Association of the United States. Attachment “A” contains a full description of the federal requirements for the CHNA content.)

A. Description of the Community Served

The towns in the northern and central parts of Carroll County (New Hampshire) are the primary service area of Memorial Hospital; several bordering towns in western Oxford County (Maine) are also served by the hospital, for a total service area of roughly 35,000. The other partners in the WMVCHC provide care in a similar geographic area, and the hospital also services a large second home and vacation population.

Carroll County is rural, with significant distances between towns, and includes a large portion of the White Mountain National Forest in its 900-square mile area. The local economy is heavily dependent on four-season tourism which encompasses the hospitality, retail, food and beverage industries. Mt. Washington Valley has been growing as a retirement and pre-retirement destination for people from throughout New England. This trend is enhanced by technology that allows people to relocate here and continue to work, as well as New Hampshire’s lack of a sales and personal income tax.

There are several key population characteristics of the Mt. Washington Valley that are significant. 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.

- The median age is 47, which is 10 years more than that of the United States and 7 years more than that of New Hampshire as a whole. 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.
- Between 2000 and 2010, Carroll County experienced population growth of 9.5%, and Oxford County 5.6%. The NH Division of Public Health estimates that between 2000 and 2030, Carroll County will experience nearly 40% growth in its population, making it the county with the largest percentage population growth in the state.2 A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.
- More than 20% of Carroll County’s population and nearly 17% of Oxford County’s population are age 65 and older. This is much higher than the United States 65+ population (12.9%), New Hampshire (13%) and Maine (15.6%). 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.

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2 2011 NH State Health Profile, NH DHHS, Division of Public Health Services
B. Participants in the Assessment

The assessment process was initiated and chaired by Memorial Hospital in collaboration with the members of the White Mountain Valley Community Health Council (WMVCHC). The hospital provided financial and in-kind support for the assessment process; however, the other members of the coalition also participated through monthly meetings and provided input into the process, and feedback on the findings. This group continues to meet to develop the implementation plans and to adopt strategies relevant to their individual organizations. Participating members of the Council include the following individuals and agency representatives who provide the indicated services:

- **Memorial Hospital**: Board member Laura Jawitz; CEO Scott McKinnon; Medical Director Dr. Raymond Rabideau; VP of Quality and Elderly Services Susan Ruka, RN PhD.
- **VNHCH (see earlier services description)**: Executive Director Sandy Ruka, RN MSN and Board member Nan Bartlett.
- **Saco River Medical Group (Primary care group including walk-in services and pediatrics)**: Heidi Root, MD and Rob Rose, MD.
- **Mineral Springs Rehabilitation Center (Long term care, assisted living, and rehabilitation)**: Administrator Barbara White and Admissions Coordinator Jane Galloway.
- **MWV Economic Council**: Executive Director Jac Cuddy
- **Northern Human Services (Mental Health and Developmental Disabilities)**: Jane Mackay and Dr. Melissa Myers
- **White Mountain Community Health Center (see earlier services description)**: Executive Director Patricia McMurry.
- **T. Murray Wellness Center, Inc.**: Owner/provider Patricia Murray, DO and Cherie Jewell
- **Additional participants** who provided occasional input and comment included Mary Reed, executive director of the Carroll County Coalition for Public Health; members of Memorial Hospital’s Community Advisory Council; and representatives from Evergreen Institute for Wellness, Carroll County United Health and Wellness Team, and SAU 9 and 13.

C. Methodology

Assessment data for the 2013 CHNA was collected utilizing the Community Health Needs Assessment Toolkit, a web-based platform designed by Community Commons, and recommended by the Centers for Disease Control & Prevention, Office of the Associate Director of Policy. The toolkit assists hospitals and organizations to better understand the needs and assets of their communities, and to collaborate more effectively in making measurable community health improvements. In addition to the collection of secondary data, input was documented from the WMVCHC members and agencies, the Patient Advisory Council at Memorial Hospital, and the executive director of the Carroll County Public Health Coalition.

The following Health Indicators for Carroll County (NH) and Oxford County (ME) were selected from five categories. These indicators were selected and organized to reflect the health issues relevant to this particular community. The appended Health Indicators Report for Carroll and Oxford Counties shows comparisons of the counties to state and national averages and Healthy People 2020 benchmarks. Additional indicators can be accessed at [http://assessment.communitycommons.org/CHNA](http://assessment.communitycommons.org/CHNA)
explains each indicator, how it was calculated, and why it represents a key driver of health status. Additional information about the data sources is available at the Community Commons website.

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicators Included in Report</th>
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<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td>Total Population</td>
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<td>Median Age</td>
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<td>Change in Total Population</td>
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<td></td>
<td>Population Age 65+</td>
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<td><strong>Social &amp; Economic Factors</strong></td>
<td>Children Eligible for Free/Reduced Price Lunch</td>
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<td></td>
<td>Population in Poverty (100% FPL)</td>
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<td>Population in Poverty (200% FPL)</td>
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<td></td>
<td>Uninsured Population</td>
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<td><strong>Clinical Care</strong></td>
<td>Access to Primary Care</td>
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<td></td>
<td>Breast Cancer Screening (Mammogram)</td>
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<td></td>
<td>Cervical Cancer Screening (Pap Test)</td>
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<td>Colon Cancer Screening (Sigmoid/Colonoscopy)</td>
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<td></td>
<td>Dental Care Utilization (Adult)</td>
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<td></td>
<td>Diabetes Management (Hemoglobin A1c Test)</td>
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<td></td>
<td>Pneumonia Vaccinations (Age 65+)</td>
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<td>Preventable Hospital Events</td>
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<td><strong>Health Behaviors</strong></td>
<td>Alcohol Consumption</td>
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<td></td>
<td>Physical Inactivity</td>
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<td></td>
<td>Tobacco Usage</td>
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<tr>
<td><strong>Health Outcomes</strong></td>
<td>Asthma Prevalence</td>
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<td></td>
<td>Breast Cancer Incidence</td>
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<td>Cancer Mortality</td>
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<td>Colon and Rectum Cancer Incidence</td>
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<td>Diabetes Prevalence</td>
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<td>Heart Disease Prevalence</td>
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<td>Lung Cancer Incidence</td>
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<td>Obesity (Adult)</td>
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<td>Overweight (Adult)</td>
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<td>Prostate Cancer Incidence</td>
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Follow-up discussions on identified health needs took place in the form of group conversations with the Memorial Hospital Patient Advisory Council and the participants of the WMVCHC. These discussions were held to establish the validity and significance of the health needs identified through the assessment. Attachment “B” is a summary of those discussions, including participants, date, and comments.

Memorial Hospital and the WMVCHC have agreed to use a Community Health Survey as one of their implementation plan strategies to more fully expand on the shared vision of a healthier community. A sample of the Community Health Survey that will be used is appended.
D. Health Needs Identified

The Mt. Washington Valley – and the state of New Hampshire – has always prided itself on the health status of its citizens and its national rankings. The area regularly meets or exceeds most national benchmarks. However, the local area is hampered by its rural nature, over-reliance on tourism and the resulting low-paying non-benefited employment, and the recent surge in its retirement-age population.

As described in the previous section, a variety of successful programs and strategies have been implemented by the hospital and other agencies to address the health needs identified in the 2010 CHNA. A review of the Health Indicators Report shows positive results in some of those areas.

Some needs cannot be addressed by the local facilities due to a lack of resources or other issues beyond their control. There is also recognition that gaps exist relative to the availability of mental health data that would benefit agencies in creating a more accurate community profile.

The Health Indicators Report for Carroll and Oxford Counties identified the following areas as being different from state and/or national averages, or the Healthy People 2020 benchmark goals. It is recommended that a determination be made as to their overall impact on the community’s health status and whether the hospital and council members have the capacity to implement meaningful and measurable change in their primary service areas.

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
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<th>Oxford County</th>
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<td>Population 65+</td>
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<tr>
<td>Social &amp; Economic Factors</td>
<td>Children Eligible for Free/Reduced Lunch</td>
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<td>Preventable Hospital Events</td>
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<td>Health Behaviors</td>
<td>Heavy Alcohol Consumption</td>
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<td>Physical Inactivity</td>
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<td>Tobacco Usage</td>
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<td>Health Outcomes</td>
<td>Breast Cancer Incidence</td>
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<td>Cancer Mortality</td>
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<td>Prostate Cancer Incidence</td>
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MOVING FORWARD

The goal for Memorial Hospital and the WMVCHC is to use the findings of this assessment and develop individual and collaborative strategies that address community health needs. The following information from the *Best Practices for Community Health Needs Assessment and Implementation Strategy Development* is offered as guidance for the hospital and council as they move forward.

In developing meaningful strategies and adopting valid implementation plans, the criteria used should be explicit, based on objective data/information, important to diverse stakeholders, and tied to a measurement system.

There are two levels of decision-making in the planning process where priority setting is helpful; selection of a broad content area of focus (e.g., asthma, adolescent substance abuse, domestic violence), and the selection of specific project activities.

Here are criteria to consider:

**For Selection of Content Areas**
- Size of the problem (i.e., number of people per 1,000, 10,000, or 100,000)
- Seriousness of the problem (i.e., impact at individual, family, and community levels)
- Economic feasibility (i.e., cost, internal resources and potential external resources)
- Available expertise (i.e., Can we make an important contribution?)
- Necessary time commitment (i.e., overall planning, implementation, evaluation)
- External salience (i.e., evidence that it is important to diverse community stakeholders)

**For Selection of Specific Project Activities**
- Target Population(s)/Communities (i.e., Will the intervention fit the needs and characteristics of the people and communities we have identified?)
- Number of people (i.e., How many people will be helped by this intervention?)
- Estimated effectiveness/efficiency (i.e., Is there track record to date on the selected approach? Are there adequate resources to implement this intervention strategy?)
- Existing efforts (i.e., Who else is working on this? What is our role? Is it meaningful? How can we best complement/enhance an existing effort?)
- Degree of controversy (i.e., Is this intervention acceptable to the community? Will this intervention offend important constituents?)

Using these points as guidance, the hospital and council can narrow their individual and collective focus, create realistic strategies, and implement targeted activities that have a greater chance of success. Over time, indicators that measure the community’s health and well-being can be used to document those areas in which change has occurred.
MEMORIAL HOSPITAL IMPLEMENTATION PLAN 2014-2015

Memorial Hospital and the White Mountain Valley Community Health Council (WMVCHC) has collaborated in their second Community Health Needs Assessment (CHNA). Their goal is to use the findings of the assessment to develop individual and collaborative strategies that address community health needs, gaps and barriers to health and human services.

Through a process of primary research, data analysis, validation and prioritization, the assessment process identified the following key themes of need:

- Aging population/Seniors
- Obesity/Child and Adult
- Wellness Education and Resources
- Access and Affordability/Primary Care

Additional areas of need were also identified:

- Mental health/Substance abuse
- Prostate and Colon cancer screening/incidence
- Dental care/Adult
- Smoking/Tobacco Use

Memorial Hospital is addressing the identified areas of community health need in the following Implementation Plan for fiscal years 2014 and 2015, after which the next Community Health Needs Assessment will be performed in 2016. In addition, the hospital's Strategic Plan 2013 contains a goal that prioritizes community health through the building of strong relationships and improvement of community health status. Their planning process has committed the organization to fostering support and growth of health initiatives in conjunction with the WMVCHC.

The hospital will work in collaboration with WMVCHC and other local and regional partners in creating meaningful outcomes, and report back to the community on an annual basis through its Community Benefits Report. The Implementation Plan that follows identifies the community health need, initiatives to be undertaken that can address and respond to the health needs, lead and collaborating agencies, and anticipated outcomes. The Implementation Plan also describes why certain identified health needs will not be addressed by the hospital.
1. Aging Population/Seniors

**Health Issue:**

*The local 65+ population represents a significant percentage of the community. This group would benefit from focused approaches to addressing their multiple health and wellness needs.*

**Initiatives:**

a. Care Transitions Team: Led by Memorial Hospital and its Advocacy Committee and in partnership with community organizations, the team will focus on improving the quality of care coordination and communication when patients are transferred from one level of care or service to another. The team is working in collaboration with physicians, Visiting Nurses, rehabilitation centers, nursing homes and health care providers, mental health services and settings at which key care transition points occur during the course of a chronic or acute illness.

   - **Strategy:** Identify key care transition points, evaluate processes that will benefit from quality or process improvements, create and implement interventions to improve the care transitions, and evaluate their effectiveness.

   - **Desired Outcomes:** Reduce avoidable readmissions, improve clinical outcomes, maximize patient self-management and enhance the patient experience.

b. Maintain support for current programs for 65+ population: Memorial Hospital offers free ongoing assistance with Advance Care Planning, and a Support Group for Caregivers of those with Alzheimer’s and Related Memory Disorders at Merriman House. The hospital is continuing to build and expand services that meet the needs of an older population including a recently added Wound Clinic and Sleep Lab, as well as expansion of the services offered through the Miranda Leavitt Diabetes Center.

c. Clinical Care Teams in Primary Care: Primary Care at Memorial Hospital is implementing Clinical Care Teams as a delivery model. This serves as a foundation for proceeding with a medical home.

2. Obesity/Child and Adult

**Health Issue:**

*The local population at both the youth and adult age levels are significantly overweight or obese. All would benefit from focused programs and activities that promote fitness, good nutrition and healthy lifestyles.*

**Initiatives:**

a. Childhood Health and Wellness Initiative: Memorial Hospital and its providers are creating and carrying out a program that is focused on bringing education to students about exercise, nutrition, physical fitness and good health habits.
• **Strategy:** Create and execute a comprehensive school-year schedule of programs and activities that inform and educate students about healthy lifestyles. Bring knowledgeable speakers, especially Memorial’s medical providers, into the schools and sponsor events on related topics. Invite partnerships with other like-minded community organizations and businesses. Funded in part by proceeds from the Memorial Hospital’s 2013 Annual Golf Tournament.

• ** Desired Outcomes:** Students will participate in the program’s fitness events and better understand the benefits of healthy lifestyle habits, physical fitness, and good nutrition.

  b. **CHOP (Community Health and Obesity Prevention):** Memorial Hospital is participating in this new collaborative project being developed and led by the MWV Community Health Council.

  • **Strategy:** Promote the creation of food, the preparation of food and non-competitive movement for young people.
  • **Desired Outcomes:** Students will understand the benefits of healthy food choices and opportunities for improved fitness through non-competitive activities.

  c. **Medically supervised exercise program for adults:** Memorial Hospital’s Heart Health & Wellness Department will seek to expand adult participation in its medically supervised exercise program.

  • **Strategy:** Increase public awareness about the benefits of the program through media information, open house events and wellness fair participation. Evaluate expansion of open hours and benefits of membership in the program. Cross-promote benefits to those with chronic issues such as diabetes, heart and lung disease.
  • **Desired Outcomes:** Participants in the program will achieve or maintain a healthy weight and fitness status as outlined in their individual goals.

3. **Wellness Education and Health Resources**

**Health Issue:**

*Community health status can be improved by informing and educating people in self-management, wellness and disease prevention strategies.*

**Initiatives:**

a. **Community Health Survey:** Led by Memorial Hospital and the WMVCHC, launch a community-wide survey to measure the public sentiment on health and wellness, and priorities for lifestyle education.

• **Strategy:** Solicit significant community participation in a health survey (online and in print) to determine viewpoints on definition of a healthy community, priorities for health education, current healthy lifestyle strategies, and interest in prevention.
• **Desired Outcomes**: Use analysis of results to create a profile of a healthy community and steps necessary to achieve it. Disseminate results to community organizations and health care providers to help shape their focus and priorities.

  b. **Maintain support for current Wellness and Health Education Programs**: Memorial Hospital offers a variety of health and wellness resources that it will continue to support. These include collaboration with Evergreen Institute for Wellness for integrative health education for the public and for hospital staff/providers; Health and Wellness Fairs that are open to the public; monthly Diabetes Support and Self-Management Groups; and Breastfeeding Support Group for new mothers. A new initiative will include a focus on Men’s Health issues, including prostate and colon cancer.

c. **Better Choices/Better Health**: Memorial Hospital and the Visiting Nurses will continue to collaborate in offering the Stanford University program in chronic disease self-management several times a year.

d. **Carroll County Coalition for Public Health**: Memorial Hospital is represented on and participating in this New Hampshire initiative that creates regional approaches to determining public health needs.

4. **Access and Affordability/Primary Care**

**Health Issue:**

*There is a significant number of uninsured and under-insured in the community whose health status could be improved by access to affordable care and/or access to health insurance.*

**Initiatives:**

  a. **Healthcare Assistance Program**: Budgeted financial support for Memorial Hospital’s free and reduced rate care program. Continued outreach of Memorial’s Healthcare Assistance Program (HAP) to identify as early as possible patients entering the system at any level who will have financial difficulty paying for services. Realignment of staff positions to provide additional financial counseling support for health insurance options under the Affordable Care Act. *Budget FY 2014: $4,600,132*

  b. **White Mountain Community Health Center**: Continued financial, clinical and administrative support for White Mountain Community Health Center. The center was created as an appropriate setting for primary care delivery to the uninsured and under-insured in the area. The center’s services include prenatal care provided by hospital midwives, primary care for all ages, wrap-around social support services for families in need, nutrition counseling, and children’s dental care.

  c. **Medication Bridge Program**: Continued support and staffing for the Medication Bridge program which helps qualifying individuals to obtain free and low cost medications from pharmaceutical companies.
d. Patient Navigator/Breast Cancer Support: Continued support and staffing for the Patient Navigator who assists women with accessing free and reduced rate programs for mammography screenings, and further helps with follow up care in the event of diagnosis and treatment. Also includes community education on breast health awareness and participation in the New Hampshire “Let No Woman Be Overlooked” screening program. Funded in part by a multi-year grant from the Susan G. Komen Foundation.

5. Memorial Hospital does not have plans to meet the following identified community health needs at this time.

- **Mental health/Substance abuse**: Other community agencies and private providers, including Northern Human Services, are leading the way in addressing these challenges. In addition, funding restraints from federal and state sources limit the ability of any local agency to sufficiently address the needs in this category. However, due to the magnitude of this issue Memorial is partnering with area agencies to identify opportunities to address needs of this population.

  In addition, a state grant-funded position for a Substance Abuse and Prevention Coordinator has been created as part of New Hampshire’s new regional public health efforts. Memorial Hospital is represented on the Carroll County Coalition for Public Health and will work in collaboration on this issue. The hospital is also exploring opportunities for adding additional mental health consulting services for inpatients.

- **Dental care/Adult**: Although past studies have found that there are a sufficient number of private dental providers in the area, there is limited access to dental insurance for the population. Most providers also limit the number of Medicaid patients they will accept. A dental clinic for all ages is administered by the local Tri-County Community Action Program which offers its services on a sliding fee scale and was created to help alleviate this problem.

- **Smoking/Tobacco Use**: Support programs exist within the school system and at the White Mountain Community Health Center to address this issue. Memorial Hospital will evaluate the need for any additional smoking cessation efforts.

**APPROVED AND ADOPTED BY THE MEMORIAL HOSPITAL GOVERNING BOARD OF TRUSTEES**

DATED: October 16, 2013
ATTACHMENTS TO COMMUNITY HEALTH NEEDS ASSESSMENT 2013
AND IMPLEMENTATION PLAN 2014

A. Federal IRS Requirements for Community Health Needs Assessment
   and Implementation Plan Content

B. Summary of Focus Group Discussions on Community Health Needs

C. 2013 Community Health Indicators Report for Carroll and Oxford Counties

D. “Towards a Healthier Community” - Community Health Survey
IRS REQUIREMENTS OF COMMUNITY HEALTH NEEDS ASSESSMENTS:
Provisions in the Affordable Care Act (ACA) require charitable hospitals to conduct community health needs assessments and adopt implementation strategies to meet needs identified through their community health needs assessment (CHNA).

A hospital must define the community it serves and assess the health needs of that community.

- Hospitals must take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health.
- Hospitals must document the CHNA in a written report that is adopted by an authorized body of the facility.
- Hospitals must make the CHNA report widely available to the public.
- Hospitals must identify significant health needs of the community.
- Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as neighborhoods or populations experiencing health disparities).
- Needs must be prioritized.
  - Hospitals may determine whether a need is significant based on all of the facts and circumstances present in the community it serves.
  - Hospital may use any criteria it deems appropriate to prioritize significant health needs including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities association with the need; and/or the importance the community places on addressing the need.
  - Definition of the community served by the hospital and a description of how the community was determined.
- Description of the process and methods used to conduct the assessment:
  - The data and other information used in the assessment.
  - Methods of collecting and analyzing this data and information.
  - Any parties with whom the hospital collaborated or contracted for assistance.
- Description of how the hospital took into account input from persons who represent the broad interests of the community it serves. More specifically, the CHNA report should:
  - Summarize the input of these persons and how and over what time period such input was provided.
  - Provide the names of organizations providing input and summarize the nature and extent of the organization’s input.
  - Describe the medically underserved, low-income, or minority populations being represented by organizations or individuals providing input.
  - The report does not need to name persons participating in forums or other groups.
A prioritized description of the significant community health needs identified through the CHNA, including a description of the process and criteria used in identifying certain health needs as significant and prioritizing such significant health needs.

A description of the potential measures and resources identified through the CHNA to address the significant health needs.

Complete version of CHNA report is conspicuously posted on the hospital’s website.

Paper copy is available for public inspection without charge.

Hospitals provide individuals who ask how to access a copy of the document online with the direct website address or URL of the web page on which document is posted.

Website clearly informs reader how to download the report. An individual must not be required to create an account or otherwise be required to provide personally identifiable information in order to access the CHNA report on the website.

Download may not require special equipment or fee.

Report available until two subsequent assessment reports are made available.

IMPLEMENTATION STRATEGY

Under the latest IRS requirements for hospital reporting, an implementation strategy is a written plan that addresses significant community health needs identified through a CHNA. Regulations don’t limit an implementation strategy to addressing only those health needs identified through the CHNA. It may also describe activities to address health needs that the hospital identifies in other ways, such as through internal quality data and patient satisfaction measurements.

The implementation strategy describe needs to describe how the hospital plans to meet the health need including:

- The actions the hospital facility intends to take
- The anticipated impact of these actions
- A plan to evaluate the impact
- The programs and resources the hospital plans to commit to address the health need
- Any planned collaboration between the hospital and other organizations in addressing the health need

If there are significant health needs that the hospital cannot meet, a brief explanation of the reason needs to be provided including, but not limited to, resource constraints, other facilities or organizations addressing the need, lack of experience or competency to effectively address the need, the need is a relatively low priority for the community, or there is a lack of identified effective interventions.

The implementation strategy for meeting health needs should describe any planned collaboration with governmental, nonprofit, or health organizations. A joint implementation strategy with a collaborative group that is adopted by a hospital must clearly identify the hospital’s particular role and responsibilities in taking the actions described in the implementation strategy, programs and resources the hospital
plans to commit to the effort, and a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relates to the hospital.

The implementation strategy is “adopted” on the date it is approved by and authorized by the governing body of the hospital and is applicable to the same taxable year in which the hospital conducts the CHNA.

The implementation strategy is reported by the hospital as an attachment to its annual Form 990. The URL of the web page on which it has made each implementation strategy widely available on a Web site must also be reported on the Form 990. The hospital must annually provide on the Form 990 a description of the actions taken during the taxable year to address the significant health needs identified through its most recent CHNA or, if no actions were taken which respect to one or more of these health needs, the reason or reasons why no actions were taken. If a hospital adopts only one implementation strategy for a three-year period, the same attachment can be used for each year.
ATTACHMENT “B”

SUMMARY OF FOCUS GROUP DISCUSSION ON COMMUNITY HEALTH NEEDS

Group: Patient Advisory Council of Memorial Hospital, North Conway, NH
Date: Tuesday, June 25, 2013
Number in attendance: 7

The group was asked to discuss several questions related to community health.

**What is your definition of a healthy community?**
Responses included that it was where people didn’t fall through the cracks; where people were made aware of the resources available to them; where providers were able to spend more than 3.6 minutes with the patient; and where people have healthy habits.

**What are the barriers to having a healthy community?**
Responses included the lack of money, lack of easy access to care, inadequate education, lack of transportation, and lack of services for mental illness.

**What issues do you see as a priority for available resources?**
Without establishing any particular ranking, the group identified priorities as substance abuse, obesity, mental health, the uninsured, aging and chronic disease issues and education, dental care, and transportation.

*Suggested solutions* offered by the group included the possibility of a “resource office” where available resources would be known, someone who could point you in the right direction, and help patients navigate through the system.
SUMMARY OF FOCUS GROUP DISCUSSION ON COMMUNITY HEALTH NEEDS

Group: White Mountain Valley Community Health Council
Discussions at several 2013 meetings on these topics

What is your definition of a healthy community?
- Affordable and timely access to health care services which includes prevention as well management of chronic and acute conditions
- Health information easily shared among places where community members receive care (continuity of care)
- Healthy lifestyle options and choices readily available and utilized (good food, activities, exercise options), health as whole person approach which includes meeting psychosocial as well as medical needs
- Mental health services available for all who need it, including strong programs that address substance misuse focusing on prevention, early intervention as well as treatment.
- Community members who feel empowered to manage their own health and partner with health care providers.
- Access to low cost medications.
- Focus on strategies to promote healthy aging. Support for caregivers and for older adults to help them maintain independence and autonomy (low cost help with tasks such as pumping gas, yard work, transportation, shopping or grocery deliveries).
- Integrative health options to promote health and well being.

What are the barriers to having a healthy community?
- Lack of health insurance
- Lack of mental health services and substance misuse prevention programs
- Silo of health care (improving)
- Lack of resources to add services or make changes
- Lack of healthy eating options in schools (costs as barrier)
- Lack of programs to prevent childhood obesity
- Lack of dental care, especially for adults

What issues do you see as a priority for available resources?
- Chronic disease
- Aging (as baby boomers age), resources to better manage conditions and healthy aging
- Prevention and management of childhood obesity
- Substance misuse (not always in our service scope)

Suggested solutions included a Geriatric Center, involving businesses in creating a culture of health (e.g., the town that lost 8000 pounds), kindness as way to promote health and well being (e.g., aim to be kindest community in country) and initiatives that focus on being kind to self, others and the earth.
2013 Health Indicators Report for Carroll and Oxford Counties

**Demographics**

**Report Area:** Carroll County, New Hampshire; Oxford County, Maine

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Social &amp; Economic Factors</th>
<th>Clinical Care</th>
<th>Health Behaviors</th>
<th>Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>Change in Total Population</td>
<td>Population Age 65</td>
<td></td>
<td>Median Age</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 105,709 people live in the 3,007.11 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2011 5-year estimates. The population density for this area, estimated at 35.15 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>Report Area</td>
<td>105,709</td>
<td>3,007.11</td>
<td>35.15</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,892</td>
<td>2,076.29</td>
<td>27.88</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,817</td>
<td>930.81</td>
<td>51.37</td>
</tr>
<tr>
<td>Maine</td>
<td>1,328,543</td>
<td>30,834.98</td>
<td>43.09</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,315,911</td>
<td>8,950.28</td>
<td>147.02</td>
</tr>
<tr>
<td>United States</td>
<td>310,346,360</td>
<td>3,530,997.60</td>
<td>87.89</td>
</tr>
</tbody>
</table>


**Median Age**

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>105,709</td>
<td>no data</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,892</td>
<td>44</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,817</td>
<td>47.30</td>
</tr>
<tr>
<td>Maine</td>
<td>1,328,543</td>
<td>42.40</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,315,911</td>
<td>40.70</td>
</tr>
</tbody>
</table>
An estimated 18.27% percent of the population in the report area was age 65 or older in 2011. According to U.S. Census Bureau estimates, a total of 19,308 older adults resided in the area. 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>Report Area</td>
<td>105,709</td>
<td>19,308</td>
<td>18.27%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,892</td>
<td>9,661</td>
<td>16.69%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,817</td>
<td>9,647</td>
<td>20.17%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,328,543</td>
<td>207,729</td>
<td>15.64%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,315,911</td>
<td>175,168</td>
<td>13.31%</td>
</tr>
<tr>
<td>United States</td>
<td>306,603,776</td>
<td>39,608,816</td>
<td>12.92%</td>
</tr>
</tbody>
</table>

Within the report area 6,926 public school students or 46.24% are eligible for Free/Reduced Price lunch out of 14,977 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.

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.
### Students Eligible for Free or Reduced-Price Lunch by School, 2010-11

Over 90.1%  
75.1 - 90.0%  
60.1 - 75.0%  
45.1 - 60.0%  
Under 45.1%  
No Data or Data Suppressed

### Population in Poverty (100% FPL)

Poverty is considered a key driver of health status.

Within the report area 11.99% or 12,400 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 necessities that contribute to poor health status.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Population in Poverty</th>
<th>Percent Population in Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>103,454</td>
<td>12,400</td>
<td>11.99%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>56,123</td>
<td>7,540</td>
<td>13.43%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,331</td>
<td>4,860</td>
<td>10.27%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,293,254</td>
<td>165,146</td>
<td>12.77%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,275,969</td>
<td>101,634</td>
<td>7.97%</td>
</tr>
<tr>
<td>United States</td>
<td>298,788,000</td>
<td>42,739,924</td>
<td>14.30%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.  

### Population Below the Poverty Level, Percent by County, 2007-11

<table>
<thead>
<tr>
<th>Percent</th>
<th>Report Area</th>
<th>Maine</th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 20.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.1 - 20.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1 - 15.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Population in Poverty (200% FPL)

In the report area 32.29% or 33,409 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.
### 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</th>
<th>Number Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>105,533</td>
<td>14,389</td>
<td>13.63%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,786</td>
<td>6,639</td>
<td>11.61%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,747</td>
<td>7,750</td>
<td>16.36%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,328,387</td>
<td>134,915</td>
<td>10.16%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,317,033</td>
<td>136,089</td>
<td>10.33%</td>
</tr>
<tr>
<td>United States</td>
<td>309,231,232</td>
<td>46,282,216</td>
<td>15.22%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.  
Data Source: [US Census Bureau, American Community Survey: 2009-11](https://www.census.gov/), Source geography: PUMA.

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**Clinical Care**

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

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

Access to Primary Care

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Primary Care Providers</th>
<th>Primary Care Provider Rate (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>105,651</td>
<td>69</td>
<td>65.30</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,833</td>
<td>35</td>
<td>60.51</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,818</td>
<td>34</td>
<td>71.10</td>
</tr>
<tr>
<td>Maine</td>
<td>1,328,361</td>
<td>1,543</td>
<td>116.10</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,316,470</td>
<td>1,286</td>
<td>97.60</td>
</tr>
<tr>
<td>United States</td>
<td>312,471,327</td>
<td>264,897</td>
<td>84.70</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.


Breast Cancer Screening (Mammogram)

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Medicare Enrollees</th>
<th>Female Medicare Enrollees Age 67-69</th>
<th>Female Medicare Enrollees with Mammogram in Past 2 Years</th>
<th>Percent Female Medicare Enrollees with Mammogram in Past 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>16,138</td>
<td>1,409</td>
<td>1,094</td>
<td>77.71%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>7,755</td>
<td>662</td>
<td>507</td>
<td>76.74%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>8,383</td>
<td>747</td>
<td>586</td>
<td>78.58%</td>
</tr>
<tr>
<td>Maine</td>
<td>164,997</td>
<td>13,303</td>
<td>9,665</td>
<td>72.66%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>149,975</td>
<td>12,407</td>
<td>9,196</td>
<td>74.13%</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.

Cervical Cancer Screening (Pap Test)

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Female Population Age 18</th>
<th>Estimated Population with Regular Pap Test</th>
<th>Percent Population with Regular Pap Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>42,320</td>
<td>34,701</td>
<td>82%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>22,713</td>
<td>18,466</td>
<td>81.30%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>19,607</td>
<td>16,235</td>
<td>82.80%</td>
</tr>
<tr>
<td>Maine</td>
<td>537,378</td>
<td>444,412</td>
<td>82.70%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>521,297</td>
<td>426,942</td>
<td>81.90%</td>
</tr>
<tr>
<td>United States</td>
<td>94,071,886</td>
<td>75,649,213</td>
<td>80.42%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

Colon Cancer Screening (Sigmoid/Colonoscopy)

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>20,110</td>
<td>12,713</td>
<td>63.22%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>10,183</td>
<td>6,558</td>
<td>64.40%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>9,927</td>
<td>6,155</td>
<td>62%</td>
</tr>
<tr>
<td>Maine</td>
<td>221,078</td>
<td>139,721</td>
<td>63.20%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>202,212</td>
<td>132,853</td>
<td>65.70%</td>
</tr>
<tr>
<td>United States</td>
<td>41,994,838</td>
<td>24,124,869</td>
<td>57.45%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Dental Care Utilization (Adult)

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population (Age 18)</th>
<th>Total Adults Without Recent Dental Exam</th>
<th>Percent Adults with No Dental Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>83,653</td>
<td>25,465</td>
<td>30.44%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>45,234</td>
<td>14,321</td>
<td>31.66%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,419</td>
<td>11,144</td>
<td>29.01%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,050,956</td>
<td>311,586</td>
<td>29.65%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,025,011</td>
<td>237,144</td>
<td>23.14%</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, 1,485 Medicare enrollees with diabetes have had an annual exam out of 1,682 Medicare enrollees in the report area with diabetes, or 88.35%. 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.
Pneumonia Vaccinations (Age 65)

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 65</th>
<th>Estimated Population with Annual Pneumonia Vaccination</th>
<th>Percent Population with Annual Pneumonia Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>18,879</td>
<td>13,445</td>
<td>71.22%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>9,532</td>
<td>6,491</td>
<td>68.10%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>9,347</td>
<td>6,954</td>
<td>74.40%</td>
</tr>
<tr>
<td>Maine</td>
<td>81,363</td>
<td>57,198</td>
<td>70.30%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>66,213</td>
<td>47,342</td>
<td>71.50%</td>
</tr>
<tr>
<td>United States</td>
<td>15,659,860</td>
<td>10,389,527</td>
<td>66.34%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. Data Source: Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the Health Indicators Warehouse. Source geography: County.
Health Behaviors

Health behaviors such as poor diet, a lack of exercise, and substance abuse contribute to poor health status.

Alcohol Consumption

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Heavily Consuming Alcohol</th>
<th>Percent Population Heavily Consuming Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>83,653</td>
<td>13,411</td>
<td>16.03%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>45,234</td>
<td>7,418</td>
<td>16.40%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,419</td>
<td>5,993</td>
<td>15.60%</td>
</tr>
<tr>
<td>Maine</td>
<td>34,650</td>
<td>5,301</td>
<td>15.30%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>433,190</td>
<td>68,011</td>
<td>15.70%</td>
</tr>
<tr>
<td>United States</td>
<td>89,135,163</td>
<td>13,385,866</td>
<td>15.02%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.
Physical Inactivity (Adult)

Within the report area, 18,651 or 21.24% 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>Report Area</td>
<td>82,161</td>
<td>18,651</td>
<td>21.24%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>44,098</td>
<td>10,848</td>
<td>23.20%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,063</td>
<td>7,803</td>
<td>19%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,018,238</td>
<td>228,032</td>
<td>21.64%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>991,944</td>
<td>215,255</td>
<td>21.31%</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.

Tobacco Usage (Current Smokers)

In the report area an estimated 17,699, or 21.16% 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>Percent Estimated Population Regularly Smoking Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>83,653</td>
<td>17,699</td>
<td>21.16%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>45,234</td>
<td>10,630</td>
<td>23.50%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,419</td>
<td>7,069</td>
<td>18.40%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,046,178</td>
<td>200,866</td>
<td>19.20%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,017,987</td>
<td>179,165</td>
<td>17.60%</td>
</tr>
<tr>
<td>United States</td>
<td>229,932,154</td>
<td>42,664,071</td>
<td>18.56%</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.
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>Total Population (Age 18)</th>
<th>Total Adults with Asthma</th>
<th>Percent Adults with Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>83,653</td>
<td>12,197</td>
<td>14.58%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>45,234</td>
<td>6,858</td>
<td>15.16%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,419</td>
<td>5,339</td>
<td>13.90%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,050,956</td>
<td>159,436</td>
<td>15.17%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,025,011</td>
<td>157,051</td>
<td>15.32%</td>
</tr>
<tr>
<td>United States</td>
<td>235,375,690</td>
<td>31,061,484</td>
<td>13.20%</td>
</tr>
</tbody>
</table>

Breast Cancer Incidence

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

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Average Annual Deaths, 2006-2010</th>
<th>Crude Death Rate (Per 100,000 Pop.)</th>
<th>Age-Adjusted Death Rate, Cancer Mortality (Per 100,000 Pop.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,883</td>
<td>279</td>
<td>264.45</td>
<td>187.87</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,769</td>
<td>157</td>
<td>270.54</td>
<td>203.69</td>
</tr>
<tr>
<td>Maine</td>
<td>1,327,824</td>
<td>3,135</td>
<td>236.10</td>
<td>188.07</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,313,881</td>
<td>2,561</td>
<td>194.93</td>
<td>177.20</td>
</tr>
<tr>
<td>United States</td>
<td>303,844,430</td>
<td>566,121</td>
<td>186.32</td>
<td>176.66</td>
</tr>
<tr>
<td><strong>HP 2020 Target</strong></td>
<td></td>
<td></td>
<td></td>
<td>&lt;= 160.6</td>
</tr>
</tbody>
</table>

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


Breast Cancer, Incidence Rate (Per 100,000 Pop.) by County, 2006-10

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

Colon and Rectum Cancer Incidence

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S. standard acccount.
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>Report Area</td>
<td>105,639</td>
<td>66</td>
<td>44.80</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,867</td>
<td>34</td>
<td>45.40</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,772</td>
<td>32</td>
<td>44.20</td>
</tr>
<tr>
<td>Maine</td>
<td>806,975</td>
<td>761</td>
<td>45.90</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>196,833</td>
<td>611</td>
<td>41.80</td>
</tr>
<tr>
<td>United States</td>
<td>no data</td>
<td>141,281</td>
<td>43.90</td>
</tr>
<tr>
<td>HP 2020 Target</td>
<td></td>
<td></td>
<td>&lt;= 38.6</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target.
Data Source: State Cancer Profiles: 2006-10, Source geography: County.

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

Diabetes Prevalence

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 20</th>
<th>Population with Diagnosed Diabetes</th>
<th>Percent Population with Diagnosed Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>82,284</td>
<td>8,335</td>
<td>8.07%</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>44,181</td>
<td>4,639</td>
<td>8.70%</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>38,103</td>
<td>3,696</td>
<td>7.40%</td>
</tr>
<tr>
<td>Maine</td>
<td>1,016,728</td>
<td>97,548</td>
<td>8.23%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>991,818</td>
<td>85,724</td>
<td>7.73%</td>
</tr>
<tr>
<td>United States</td>
<td>228,834,127</td>
<td>21,876,232</td>
<td>8.95%</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.

Heart Disease Prevalence
3,670, or 4.39% 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.

### Lung Cancer Incidence

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 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>Report Area</td>
<td>105,639</td>
<td>113</td>
<td>73.90</td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>57,867</td>
<td>66</td>
<td>84.90</td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>47,772</td>
<td>47</td>
<td>62.60</td>
</tr>
<tr>
<td>Maine</td>
<td>806,975</td>
<td>1,289</td>
<td>77.40</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>196,833</td>
<td>1,013</td>
<td>69.80</td>
</tr>
<tr>
<td>United States</td>
<td>no data</td>
<td>208,652</td>
<td>64.90</td>
</tr>
</tbody>
</table>

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

### Obesity (Adult)

27.38% 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
Prostate Cancer Incidence

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

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, ACS 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>Report Area</td>
<td>52,355</td>
<td>131</td>
<td><strong>170.70</strong></td>
</tr>
<tr>
<td>Oxford County, ME</td>
<td>28,652</td>
<td>55</td>
<td><strong>143</strong></td>
</tr>
<tr>
<td>Carroll County, NH</td>
<td>23,703</td>
<td>76</td>
<td><strong>196.60</strong></td>
</tr>
<tr>
<td>Maine</td>
<td>400,362</td>
<td>1,148</td>
<td><strong>144.70</strong></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>97,841</td>
<td>1,108</td>
<td><strong>155.30</strong></td>
</tr>
<tr>
<td>United States</td>
<td>no data</td>
<td>215,232</td>
<td><strong>143.70</strong></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, 2006-10

- Over 160.0
- 140.1 - 160.0
- 120.1 - 140.0
- Under 120.1
- No Data or Data Suppressed
Data Background

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

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

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

Methodology

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

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

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

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).

Median Age

Data Background

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

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

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

Methodology

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

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

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 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

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

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

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).

Children Eligible for Free/Reduced Price Lunch

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

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

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

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

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

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

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

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.

Population in Poverty (100% FPL)

Data Background

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

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

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

Methodology

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

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

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

Notes

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 2007-2011. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:
\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

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

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.

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

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

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

Methodology
Population counts for socio-economic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 3 year period 2009-2011. Data are summarized to 2010 Public Use Micro Area (PUMA) boundaries. Health insurance coverage status is classified in the ACS according to yes/no responses to questions (16a - 16h) representing eight categories of health insurance, including: Employer-based, Directly-purchased, Medicare, Medicaid/Medical Assistance, TRICARE, VA health care, Indian Health Service, and Other. An eligibility edit was applied to give Medicaid, Medicare, and TRICARE coverage to individuals based on program eligibility rules. People were considered insured if they reported at least one “yes” to Questions 16a - 16h. Indicator statistics are measured as a percentage of the total population using the following formula:
\[
\text{Percentage} = \frac{\text{[Subgroup Population]}}{\text{[Total Population]}} \times 100
\]

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

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
Access to Primary Care

Data Background

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

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

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

Methodology

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

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

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

Notes

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

Breast Cancer Screening (Mammogram)

Data Background

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

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

Methodology

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

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

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.

Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.

Cervical Cancer Screening (Pap Test)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is

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

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

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

Methodology

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

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

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

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

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

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.

Colon Cancer Screening (Sigmoid/Colonoscopy)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is...

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

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

Overview: BRFSS 2010.

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

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

Methodology

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

"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams? For a SIGMOIDOSCOPY, a flexible tube is inserted into the rectum to look for problems. A COLONOSCOPY is similar but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. Was your MOST RECENT exam a sigmoidoscopy or a colonoscopy? How long has it been since you had your last sigmoidoscopy or colonoscopy?"

Respondents are considered to be have had a Sigmoidoscopy/Colonoscopy if they answer that they had ever had a test. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 50 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

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

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

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

Dental Care Utilization (Adult)

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

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

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

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

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

>“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:

Adults Without Recent Dental Exam = (Indicator Percentage / 100) * [Total Population]

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

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

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 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:

Percentage = [Number Screened] / [Total Patients] *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.

**Pneumonia Vaccinations (Age 65)**

**Data Background**

The Behavioral Risk Factor Surveillance System (BRFSS) is

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

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

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

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

**Methodology**

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

"Have you EVER had a pneumonia shot? A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?"

Respondents are considered to have had a pneumonia vaccination if they answer that they had ever had a vaccine. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 65 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

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

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS website. 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.

**Preventable Hospital Events**

**Data Background**

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

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

**Methodology**

The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data tables express the rate of Medicare Part A patients discharged from the hospital for preventable / ambulatory care sensitive (ACS) conditions like asthma, diabetes, pneumonia, or COPD, based on the following formula:

\[
\text{Rate} = \frac{\text{[ACS Condition Discharges]}}{\text{[Total Patients]}} \times 10,000
\]

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.

Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.
Alcohol Consumption

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is...

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

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

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

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

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

“One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?”

Respondents are considered heavy drinkers if they were male and reported having more than 2 drinks per day, or females that reported having more than 1 drink per day. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

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

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

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.

Physical Inactivity (Adult)

Data Background
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publically available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Methodology
Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention’s National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

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

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
Les indices de santé comportementale estivale (fumeurs actuels) peuvent être utilisés pour surveiller les habitudes de santé préventives. Les répondants étaient considérés comme diabétiques si ils répondirent “oui” à la question, “Un médecin vous a-t-il dit que vous aviez le diabète ?” Les femmes qui indiquaient qu’elles avaient seulement diabète pendant la grossesse ne sont pas considérées comme diabétiques. Les répondants étaient considérés obèses si leur indice de masse corporelle était de 30 ou plus. L’indice de masse corporelle (pondération [kg]/[m²]) a été déduit du rapport de self-report et de l’indice de masse corporelle. Les répondants étaient considérés comme physiquement inactifs si ils répondirent “non” à la question, “Durant le mois dernier, en dehors de votre travail habituel, avez-vous participé à des activités physiques régulières ou des exercices tels que la course, le jardinage, le golf, le camping, ou faire de l’exercice ?”


Citation : Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

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.

Tobacco Usage (Current Smokers)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is:

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

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

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

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

Methodology

Indicator percentages are acquired for years 2005-2011 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Data are based on the percentage of respondents answering the following question:

“Do you now smoke cigarettes every day, some days, or not at all?”

Respondents are considered smokers if they reported smoking every day or some days. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adult smokers) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

[Adults Smokers] = ([Indicator Percentage] / 100) * [Total Population].

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

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.
Breast Cancer Incidence

Data Background

The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

Methodology

Annual incidence rates are acquired for all US states and counties as an average for years 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. In order to perform aggregate (multi-county or service area) estimates with the data provided, age-adjusted cancer incidence rates are back-calculated using the following formula:

**Asthma Prevalence**

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is...

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

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

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

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

Methodology

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

"Have you ever been told by a doctor, nurse, or health professional that you have Asthma?"

This indicator represents the percentage of those persons who answered “yes”. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

**Adults Diagnosed with Asthma = ([Indicator Percentage] / 100) * [Total Population]**

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

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

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.

Breast Cancer Incidence

Data Background

The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

Methodology

Annual incidence rates are acquired for all US states and counties as an average for years 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. In order to perform aggregate (multi-county or service area) estimates with the data provided, age-adjusted cancer incidence rates are back-calculated using the following formula:
Cancer Mortality

SUM([Age-Adjusted Rate/100,000] * SUM[Total Population]) / SUM[Total Population] * 100,000.

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

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 Mortality

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

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2006-2010 based on a selection of codes from the International Classification of Diseases (ICD), Version 10. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2010) is available from the World Health Organization.

Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

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 heart disease: I11, I20-I25
- Chronic lower respiratory disease: J40-J47
- Intentional self-harm (suicide): X60-X64, Y87.0
- Malignant neoplasm (cancer): C00-C97
- 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.
Colon and Rectum Cancer Incidence

Data Background
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

Methodology
Annual incidence rates are acquired for all US states and counties as an average for years 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. In order to perform aggregate (multi-county or service area) estimates with the data provided, age-adjusted incidence rates are back-calculated using the following formula:

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

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

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 Mississippi.
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

Diabetes Prevalence

Data Background
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces 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:

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

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.

Heart Disease Prevalence

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is

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

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

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

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

Methodology

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

- Has a doctor, nurse, or other health professional ever told you that you had any of the following:
  - Ever told you had a heart attack, also called myocardial infarction?
  - Ever told you had angina or coronary heart disease?
  - Ever told you had a stroke?

This indicator represents the percentage of those persons who answered that “yes”, they have been diagnosed with angina or coronary heart disease. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

Adults Diagnosed with Heart Disease = ([Indicator Percentage] / 100) * [Total Population].

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

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

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 and 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.

**Lung Cancer Incidence**

**Data Background**
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles web site provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties.

State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians’ offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC’s National Program of Cancer Registries and the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the [State Cancer Profiles website](https://www.cancer.gov/canercare/states/aspiring_cancer). In order to perform aggregate (multi-county or service area) estimates with the data provided, age-adjusted cancer incidence rates are back-calculated using the following formula:

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

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the [SEER*Stat website](https://seer.cancer.gov/).

**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](https://wonder.cdc.gov/). 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.

**Obesity (Adult)**

**Data Background**
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces 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:

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 (Adult)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is

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

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

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

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

Methodology

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

"About how much do you weigh without shoes?" and "About how tall are you without shoes?"

These responses were combined to determine a respondent's Body Mass Index (BMI). BMI is calculated as weight in kilograms divided by height in meters squared. Persons with a BMI from 25.0-29.9 are considered overweight. Data only pertain to the non-institutionalized population aged 18 and up and are weighted to reflect the total county population, including non-respondents, using the methods described in the BRFSS Comparability of Data documentation. Population numerators (estimated number of adults exercising each risk behavior) are not provided in the annual survey data and were generated for the data tables using the following formula:

Adults Overweight = \( \frac{\text{Indicator Percentage}}{100} \times \text{Total Population} \).
The population figures used for these estimates are acquired from the American Community Survey (ACS) 2006-2010 five year estimates.

Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the 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.

Prostate Cancer Incidence

Data Background
The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles 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. In order to perform aggregate (multi-county or service area) estimates with the data provided, age-adjusted cancer incidence rates are back-calculated using the following formula:

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

In compliance with the State Cancer Profiles methodology, population figures are acquired from the U.S. Census Bureau American Community Survey.

The new case counts used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, and by the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Program. For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

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.
Part I - A Healthy Community

Your vision of a healthy community is important to us! MEMORIAL HOSPITAL and the WHITE MOUNTAIN VALLEY COMMUNITY HEALTH COUNCIL are conducting this survey. The information we collect will help us better understand our community’s vision of a healthy community and the current unmet needs. Your responses are anonymous and confidential.

The purpose of the first section is to get your opinions about community health issues and our quality of life.

1. In the following list, what do you think are the three most important factors that create a "Healthy Community". CHOOSE ONLY THREE.

   - Good place to raise children
   - Low crime / safe neighborhoods
   - Good schools
   - Access to health care services
   - Parks and recreation
   - Clean environment
   - Affordable housing

   Other (please specify)

2. In the following list, what do you think are the three most important “health issues” that have the greatest impact on the quality of life in our community? CHOOSE ONLY THREE.

   - Aging issues
   - Cancers
   - Child abuse / neglect
   - Dental problems
   - Diabetes
   - Heart disease and stroke
   - Infectious Diseases (e.g., hepatitis, TB, etc.)
   - Mental health problems
   - Motor vehicle crash injuries
   - Obesity
   - Respiratory / lung disease
   - Substance Use/Abuse
   - Suicide
   - Teenage pregnancy
   - Tobacco use
   - Violence/domestic violence

   Other (please specify)
3. In the following list, what do you think are the three most detrimental “risky behaviors” which have the greatest negative impact on our community's overall health. CHOOSE ONLY THREE.

- Alcohol and drug abuse
- Being overweight
- Dropping out of school
- Lack of exercise
- Lack of pre-natal/maternity care
- Not getting regular health check-ups
- Poor eating habits
- Tobacco use
- Not using seat belts / child safety seats
- Unsafe sex
- Unsecured firearms

Other (please specify)

Part 2 - Quality of Life in Our Community

In this section, please share your opinion about the quality of life in our community. Answer based on a scale of strong agreement to strong disagreement.

4. I am satisfied with the quality of life in our community. (Consider your sense of safety, well being, participation in community life and associations, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

5. I am satisfied with the health care system in our community. (Consider access, cost, availability, quality, and options in health care services and providers)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No
6. I feel safe in my neighborhood and community. (Consider crime, vandalism, delinquency, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

7. If I need medical or mental health services, I know what my options are and where I can get help.

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

8. There are safe and affordable forms of exercise that my family and I can access in our community.

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

9. This a good community in which to grow old. (Consider elder-friendly housing, transportation, home care, social support for the elderly, meals on wheels, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No
10. This is a good community in which to raise children. (Consider school quality, day care, after school programs, recreation, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

11. There is sufficient economic opportunity in this community. (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly No

12. There are sufficient networks of support for individuals and families in our community during times of stress and need. (Consider neighborhoods, support groups, faith community, outreach, agencies, social organizations, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly no

13. Residents in our community believe that this is a positive place in which to live. (Consider the general atmosphere of the community, interactions between groups, problem solving, etc.)

- Strongly yes
- Yes
- Neutral
- No
- Strongly no
14. Residents in our community believe that, individually and collectively, they can make this a better place to live.

- Strongly yes
- Yes
- Neutral
- No
- Strongly no

Part 3 - Demographics

The purpose of this section is to help us identify how different segments of our community view various health concerns.

15. In what ZIP code is your home located? (enter 5-digit ZIP code)

16. Are you male or female?

- Male
- Female

17. How many people living in your household are currently 65 years or older?

18. Which of the following categories best describes your employment status?

- Employed, working 1-39 hours per week
- Employed, working 40 or more hours per week
- Not employed, looking for work
- Not employed, NOT looking for work
- Retired
- Disabled, not able to work

19. Do you currently have health insurance, or not? (Includes Medicare, Medicaid, and any form of private insurance)

- Yes, I do
- No, I do not

20. Does everyone in your household currently have health insurance, or not?

- Yes, everyone does
- No, everyone does not
21. Were you without health insurance for any amount of time in the past 12 months, or not?

☐ Yes, I was
☐ No, I was not

22. Who pays for your health insurance? (Check all that apply)

☐ State government
☐ Current employer
☐ Former employer
☐ National government
☐ Local government
☐ Self funded
☐ Other (please specify)

23. If there was a time in the past 12 months when you needed to see a healthcare provider but were not able to, please tell us why. Check all that apply.

☐ Cost too much
☐ Could not get an appointment
☐ I don't have insurance
☐ I don't have a medical provider
☐ Office hours did not work for my schedule
☐ Unable to get there/transportation issues
☐ Too busy caring for family members
☐ I have not needed to see a healthcare provider in the past year
☐ I was able to see a healthcare provider when I needed one

Other (please specify)

Part 4 - Personal Health and Wellness

The purpose of this section is to help us better understand the health and wellness habits of our community.
24. In a typical week, how many days do you exercise?

- I don’t regularly exercise
- Once a week
- 2 to 4 days a week
- 5 to 7 days a week

25. In a typical week, how often do you eat each of the following foods?

<table>
<thead>
<tr>
<th></th>
<th>Once a week</th>
<th>2-4 times a week</th>
<th>Once a day</th>
<th>2-4 times a day</th>
<th>5 or more times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole Grains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. In a typical week, how many meals do you cook/prepare at home for yourself and your family?

- I do not regularly cook/prepare meals
- 1 to 3 a week
- 3 to 5 a week
- 5 to 7 a week
- More than 7 a week

27. Have you purchased locally grown produce or food in the past 12 months? If so, please select all the ways that apply.

- At a Farmers Market
- Through shares with a Community Supported Agriculture (CSA) group
- Directly from a local farmer or farmstand
- I have not purchased any local foods
- I have a home garden and grow seasonal produce/vegetables
28. Have you ever been told by a healthcare provider that you (or your child) have any of the following conditions? If so, please check all that apply:

- [ ] Asthma
- [ ] Arthritis
- [ ] Anxiety/Panic Attacks
- [ ] Attention Deficit Hyperactivity Disorder (ADD/ADHA)
- [ ] Autism
- [ ] Bladder Problems
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Blood Sugar
- [ ] High Cholesterol
- [ ] Kidney Disease
- [ ] Obesity
- [ ] Respiratory Disease/COPD
- [ ] Sleep Apnea

Other chronic condition (please specify)

29. Do you use tobacco?

- [ ] Yes
- [ ] I used to use it but I quit
- [ ] No, I have never used it

30. Do you drink alcohol?

- [ ] Yes, daily
- [ ] Yes, a few times a week
- [ ] Yes, a few times a month
- [ ] Occasionally or rarely
- [ ] No, I do not drink

31. Do you use marijuana?

- [ ] Yes, frequently
- [ ] Yes, occasionally
- [ ] I used to use it but I quit
- [ ] No, I have never used it

32. Have you ever used prescription medications for recreational purposes or for reasons other than what they were prescribed for?

- [ ] Yes
- [ ] No
33. In the past year, have you used any of the following approaches to manage symptoms and/or for your overall well-being? (Please check all that apply.)

- [ ] Acupuncture
- [ ] Ayurvedic medicine
- [ ] Dietary products/supplements (vitamins, herbs, probiotics)
- [ ] Massage therapy
- [ ] Movement therapy (Feldenkrais, Pilates, Rolfing, Trager)
- [ ] Meditation (Mindfulness, Transcendental)
- [ ] Healing touch (Reiki)
- [ ] Homeopathy, naturopathy
- [ ] Hypnotherapy
- [ ] Relaxation techniques (Breathing exercises, guided imagery)
- [ ] Spinal manipulation (Osteopathic, chiropractic)
- [ ] Tai Chi
- [ ] Yoga

Other (please specify)

34. If you are 50 or older, have you had a colonoscopy in the last 10 years?

- [ ] Yes
- [ ] No
- [ ] Not Sure
- [ ] I am under the age of 50

35. FOR WOMEN ONLY: When was the last time you had a Pap Smear?

- [ ] Within the last year
- [ ] Within the last 1-3 years
- [ ] Within the last 3-5 years
- [ ] More than 5 years ago
- [ ] Never
36. FOR WOMEN AGE 40 AND OLDER: When was the last time you had a mammogram?

- ☐ Within the last year
- ☐ Within the last 1-3 years
- ☐ Within the last 3-5 years
- ☐ More than 5 years ago
- ☐ Never
- ☐ I am under the age of 40

THANK YOU FOR YOUR PARTICIPATION!

We appreciate the time and effort you invested in answering our survey. Your input will help Memorial Hospital and the members of the WHITE MOUNTAIN VALLEY COMMUNITY HEALTH COUNCIL better understand the health issues and priorities of those who live here. This is an ongoing effort to develop strategies and plans for improving the overall health and well-being of our community.