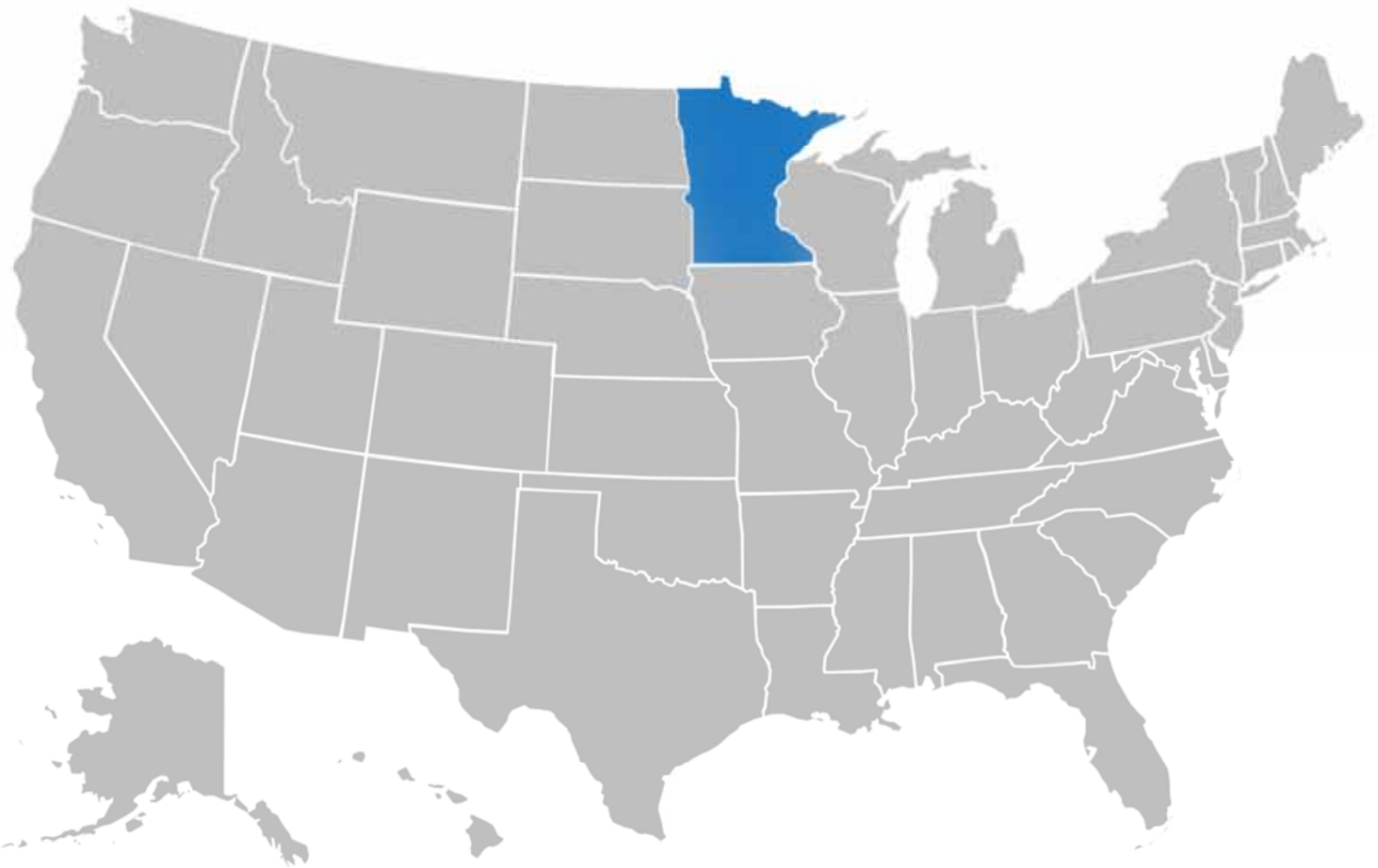


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Minnesota



2018 County Health Rankings Report

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.



Support provided by

Robert Wood Johnson Foundation



Introduction

Ranking the health of nearly every county in the nation (based on the model to the right), County Health Rankings & Roadmaps (CHR&R) illustrates what we know when it comes to what is keeping people healthy or making them sick and shows what we can do to create healthier places to live, learn, work and play. CHR&R brings actionable data, evidence, guidance and stories to communities to make it easier for people to be healthy in their neighborhoods, schools and workplaces.

Our country has achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking and infectious diseases. But when you look closer, there are significant differences in health outcomes according to where we live, how much money we make or how we are treated. The data show that not everyone has benefited in the same way from these health improvements. There are fewer opportunities and resources for better health among groups that have been historically marginalized including people of color, people living in poverty, people with physical or mental disabilities, LGBTQ persons, and women.



This report explores the size and nature of health differences by place and race/ethnicity in Minnesota and how state and community leaders can take action to create environments where all residents have the opportunity to live their healthiest lives. Specifically, this report will help illuminate:

1. What health equity is and why it matters
2. Differences in health outcomes within the state by place and racial/ethnic groups
3. Differences in health factors within the state by place and racial/ethnic groups
4. What communities can do to create opportunity and health for all

The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

What Is Health Equity?

We live in a nation that prides itself on being a land of opportunity - a place where everyone has a fair chance to lead the healthiest life possible regardless of where we live, how we are treated, or the circumstances we were born into; this is the prospect of health equity. However, this is not always our reality. More often the choices we make depend on the opportunities we have, such as a quality education, access to healthy foods and living in safe, affordable housing in crime-free neighborhoods. These opportunities are not the same for everyone.

Health disparities emerge when some groups of people have more access to opportunities and resources over their lifetime and across generations. For example, when children live in families with higher incomes, they typically experience stable housing in safer neighborhoods, have access to better-resourced and higher quality schools, and are better prepared for living wage jobs leading to upward economic mobility and good health. When children live in families with lower incomes and do not have access to these same opportunities, they face challenges to gaining a foothold on the ladder to economic security that helps them thrive.

Differences in opportunity do not come about on their own or because of the actions of individuals alone. Often, they are the result of policies and practices at many levels that have created deep-rooted barriers to good health, such as unfair bank lending practices, school funding based on local property taxes, and policing and prison sentencing. The collective effect is that a fair and just opportunity to live a long and healthy life is not a reality for everyone. Now is the time to change how things are done.

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health and in the conditions and resources needed for optimal health by improving the health of marginalized groups, not by worsening the health of others. Our progress toward health equity will be measured by how health disparities change over time. This report provides data on differences in health and opportunities in Minnesota that can help identify where action is needed to achieve greater equity and offers information on how to move from data to action.



Why Does It Matter?

Population projections indicate that our nation's youth are increasingly more racially and ethnically diverse. A healthy beginning is essential to a healthy future for our children and our nation.

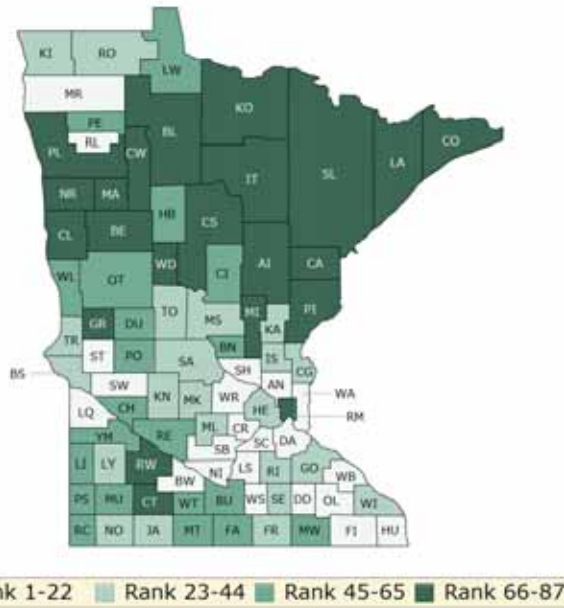
Yet, child poverty rates remain high with nearly one in five living in poverty. And, in the majority of U.S. counties, rates for Black or Hispanic children are even higher than rates for White children.

Investing in the health and well-being of ALL young people now and in years to come is vital to our nation's future success and prosperity.

Differences in Health Outcomes within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Outcomes?

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (% of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the % of low birth weight newborns. Detailed information on the underlying measures is available at countyhealthrankings.org



The green map above shows the distribution of Minnesota’s **health outcomes**, based on an equal weighting of length and quality of life. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 12 at the end of this report.

How Do Health Outcomes Vary by Race/Ethnicity?

Length and quality of life vary not only based on where we live, but also by our racial/ethnic background. In Minnesota there are differences by race/ethnicity in length and quality of life that are masked when we only look at differences by place. The table below presents the five underlying measures that make up the Health Outcomes Rank. Explore the table to see how health differs between the healthiest and the least healthy counties in Minnesota, and among racial/ethnic groups.

Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in Minnesota

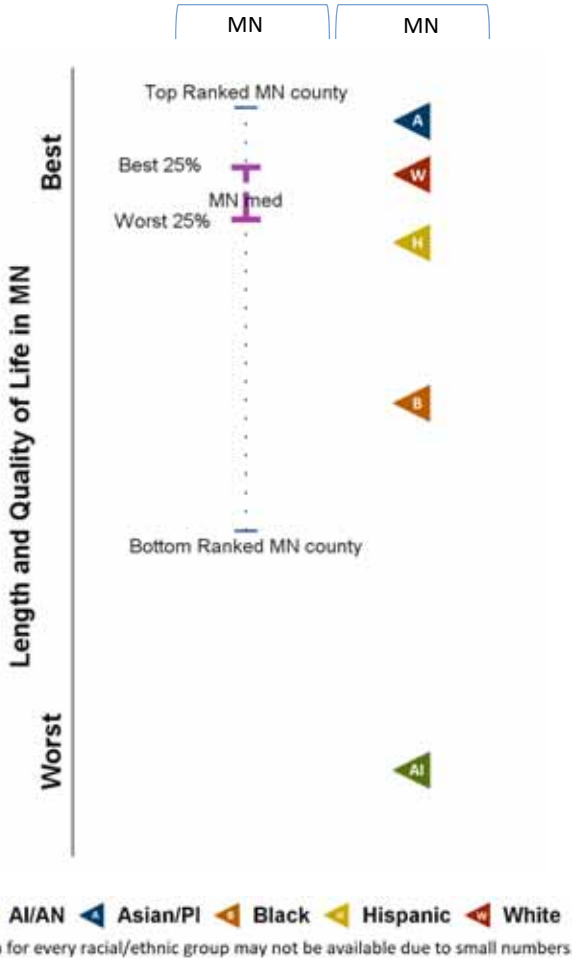
| | Healthiest MN County | Least Healthy MN County | AI/AN | Asian/PI | Black | Hispanic | White |
|---|----------------------|-------------------------|--------|----------|-------|----------|-------|
| Premature Death (years lost/100,000) | 3,500 | 12,900 | 16,800 | 4,000 | 8,400 | 3,700 | 4,800 |
| Poor or Fair Health (%) | 10% | 21% | 29% | 10% | 16% | 27% | 11% |
| Poor Physical Health Days (avg) | 2.5 | 4.6 | 5.5 | 2.0 | 4.1 | 3.5 | 2.9 |
| Poor Mental Health Days (avg) | 2.6 | 4.3 | 6.0 | 2.1 | 3.6 | 3.1 | 3.2 |
| Low Birthweight (%) | 6% | 7% | 8% | 8% | 10% | 6% | 6% |

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

N/A = Not available. Data for all racial/ethnic groups may not be available due to small numbers

Health Outcomes in Minnesota

Differences by: **Place** **Race/Ethnicity**



AI/AN - American Indian/Alaskan Native/Native American

Asian/PI - Asian/Pacific Islander

The graphic to the left compares measures of length and quality of life by place (Health Outcomes ranks) and by race/ethnicity. To learn more about this composite measure, see the technical notes on page 13.

In Minnesota, measures of length and quality of life indicate:

- American Indians/Alaskan Natives are less healthy than those living in the bottom ranked county.
- Asians/Pacific Islanders are most similar in health to those living in the healthiest quartile of counties.
- Blacks are most similar in health to those living in the least healthy quartile of counties.
- Hispanics are most similar in health to those living in the least healthy quartile of counties.
- Whites are most similar in health to those living in the middle 50% of counties.

(Quartiles refer to the map on page 4.)

Across the US, values for measures of length and quality of life for Native American, Black and Hispanic residents are regularly worse than for Whites and Asians. For example, even in the healthiest counties in the US, Black and American Indian premature death rates are about 1.5 times higher than White rates. Not only are these differences unjust and avoidable, they will also negatively impact our changing nation's future prosperity.



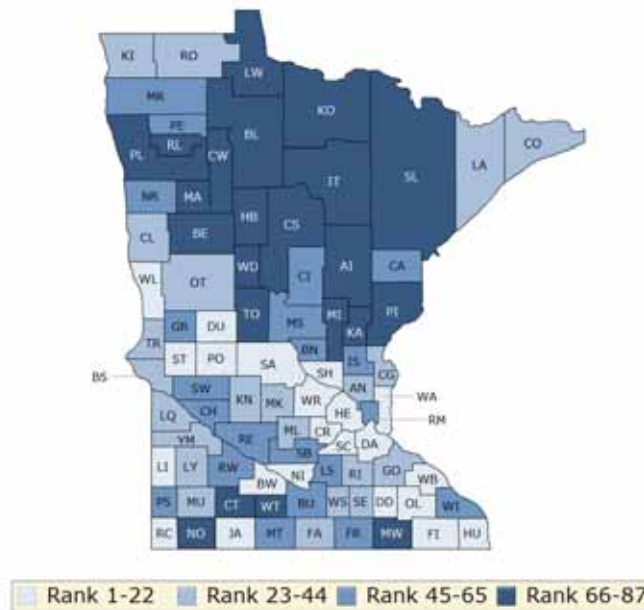
Changing the Course in Kansas City

A decade ago, public health officials identified an 8-year gap in life expectancy between the city's White and Black populations. Segregation and discrimination over the past century fueled this disparity, but community residents and city leaders joined forces to tackle tough conversations on race, stem the violence, increase educational opportunities, improve access to care and ensure economic justice. Today the disparity in life expectancy has been reduced to 6.9 years. Learn more at rwjf.org/prize.

Differences in Health Factors within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Factors?

Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family & social support, community safety), and the physical environment (air & water quality, housing & transit).



The blue map above shows the distribution of Minnesota’s **health factors** based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Detailed information on the underlying measures is available at countyhealthrankings.org. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 12.

What are the Factors That Drive Health and Health Equity?

Health is influenced by a range of factors. However, social and economic factors, like connected and supportive communities, good schools, stable jobs, and safe neighborhoods, are foundational to achieving long and healthy lives. These social and economic factors also influence other important drivers of health and health equity. Social and economic factors impact our ability to make healthy choices, afford medical care or housing, and even manage stress leading to serious health problems. The choices we make are based on the choices we have.

Across the nation, there are meaningful differences in social and economic factors among counties and among racial/ethnic groups. Even within counties, policies and practices marginalize many racial and ethnic groups, keeping them from resources and supports necessary to thrive. Limited access to opportunities is what creates disparities in health, impacting how well and how long we live.

How Do Social and Economic Opportunities for Health Vary in Minnesota?

Social and economic factors vary depending on where we live and by our racial/ethnic background. The following four data graphics illustrate differences among counties and by racial/ethnic groups in social and economic opportunities for health in Minnesota. These graphics show that it is important to explore differences by place and race/ethnicity in order to tell a more holistic story about the health of your community.

This report explores state-wide data. To dive deeper into your county data, visit [Use the Data](http://www.countyhealthrankings.org) at www.countyhealthrankings.org

Consider these questions as you look at the data graphics throughout this report:

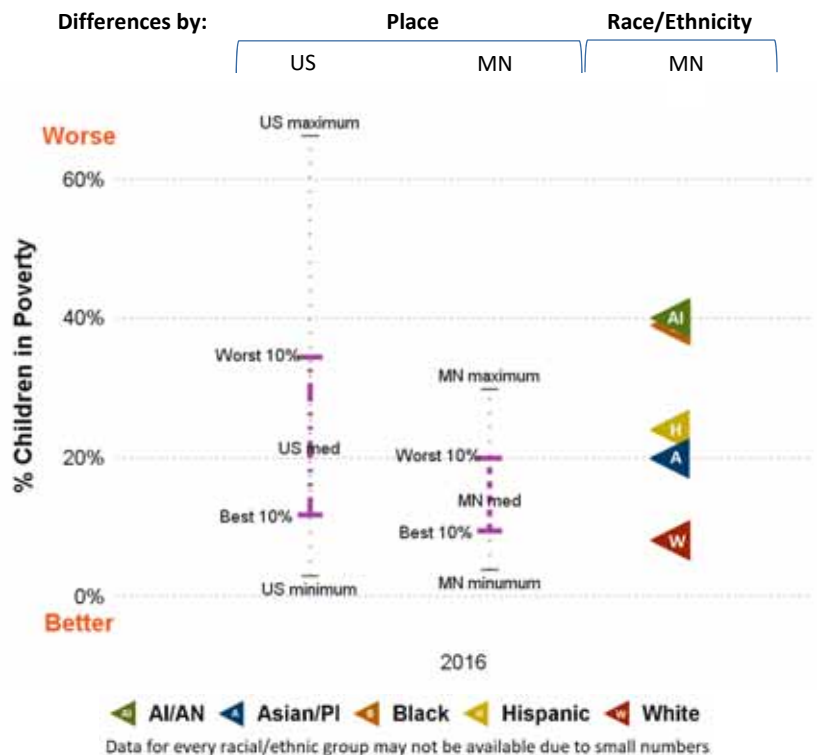
- What differences do you see among counties in your state?
- What differences do you see by racial/ethnic groups in your state?
- How do counties in your state compare to all U.S. counties?
- What patterns do you see? For example, do some racial/ethnic groups fare better or worse across measures?

CHILDREN IN POVERTY

Poverty limits opportunities for quality housing, safe neighborhoods, healthy food, living wage jobs, and quality education. As poverty and related stress increase, health worsens.

The graphic to the right shows:

- In Minnesota, 13% of children are living in poverty compared to the U.S. rate of 20%.
- Children in poverty rates among Minnesota counties range from 4% to 30%.
- Children in poverty rates among racial/ethnic groups in Minnesota range from 8% to 40%.



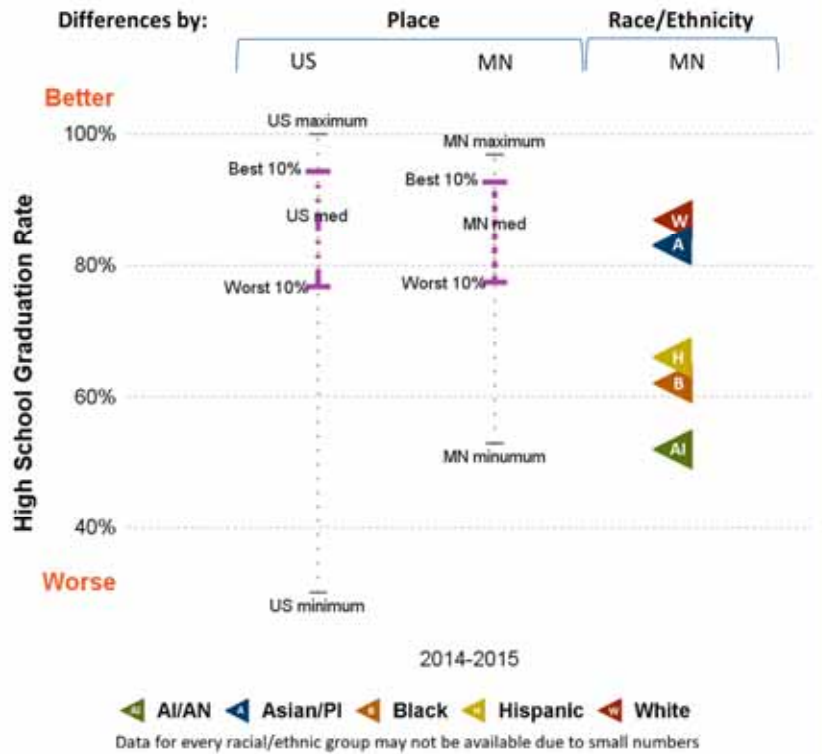
US and state values and the state minimum and maximum can be found in the table on page 14
 American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

HIGH SCHOOL GRADUATION

Higher rates of educational achievement are linked to better jobs and higher incomes resulting in better health. Education is also connected to lifespan: on average, college graduates live nine years longer than those who didn't complete high school.

The graphic to the right shows:

- Minnesota's high school graduation rate is 83% compared to the U.S. rate of 83%.
- High school graduation rates among Minnesota counties range from 53% to 97%.
- High school graduation rates among racial/ethnic groups in Minnesota range from 52% to 87%.

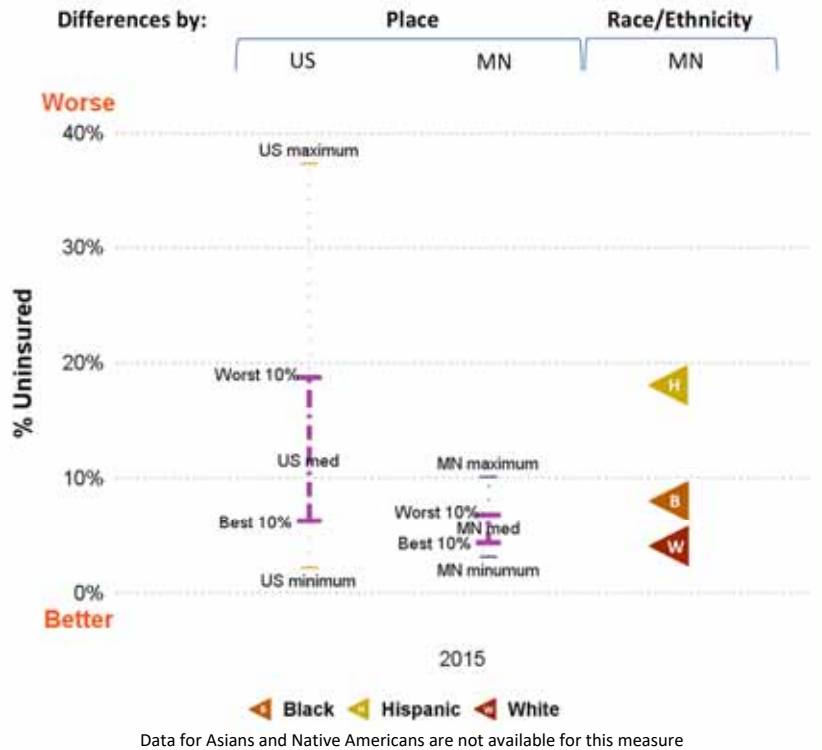


HEALTH INSURANCE

Health insurance helps individuals and families access needed primary care, specialists, and emergency care. Those without insurance are often diagnosed at later, less treatable disease stages and at higher costs than those with insurance.

The graphic to the right shows:

- The uninsured rate in Minnesota is 5% compared to the U.S. rate of 11%.
- Uninsured rates among Minnesota counties range from 3% to 10%.
- Uninsured rates among racial/ethnic groups in Minnesota range from 4% to 18%.

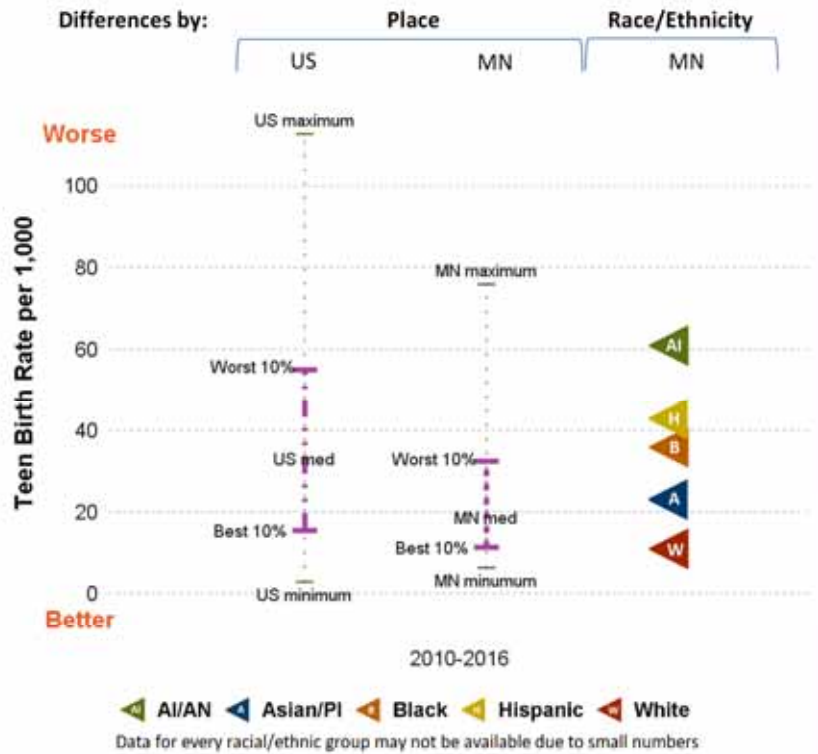


TEEN BIRTHS

Teenage motherhood is more likely to occur in communities with fewer opportunities for education or jobs. Teen mothers are less likely to complete high school and face challenges to upward economic mobility. In turn, their children often have fewer social and economic supports and worse health outcomes.

The graphic to the right shows:

- The teen birth rate in Minnesota is 17 births per 1,000 female population, ages 15-19, compared to the U.S. rate of 27 per 1,000.
- Teen birth rates among Minnesota counties range from 6 to 76 per 1,000.
- Teen births for racial/ethnic groups in Minnesota range from 11 to 61 per 1,000.



US and state values and the state minimum and maximum can be found in the table on page 14
 American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)



Spartanburg County Closing the Gap

Community leaders in Spartanburg County, SC took a good hard look at their data in 2008 and discovered they had the worst teen birth rate in the whole state. Deciding to face this issue head on, they brought together teens, providers, parents, and partners to create solutions - a warm welcoming teen center, accessible and respectful reproductive health care, and open discussions about sexuality. Recent data show improvements - rates have receded by 50% from 2010 to 2016 for all 15-19 year olds. And while disparities in teen births among racial/ethnic groups in SC continue, the gap has closed for teen births among Black and White females in Spartanburg County (in 2016, 23.3 per 1,000 and 23.9 per 1,000, respectively). Learn more at rwjf.org/prize.

What Communities Can Do to Create Opportunity and Health for All

This report shows some of the differences in opportunity for people in Minnesota based on where they live and their race or ethnicity. But how can you turn this information into action? Below are some evidence-informed approaches to consider as your community moves forward:

Invest in education from early childhood through adulthood to boost employment and career prospects

- Strengthen parents' skills, including ways to foster children's learning and development in home and community settings
- Undertake policy initiatives to improve pre-K-12 education in the classroom, school, district or state level, focusing on raising school attendance and high school graduation rates
- Implement community and school-based supports that will improve access to and quality of early childhood care and education, beginning in infancy
- Offer alternative learning models and technology to help students develop social and work-ready skills
- Support higher education opportunity for all through college application assistance and financial aid

Increase or supplement income and support asset development in low income households

- Increase public and private sector wages and offer benefits for low-income earners through living wages and paid leave
- Expand eligibility for earned-income tax credits and increase credit amount
- Assist parents by expanding refundable child care tax credits and increasing child care subsidies

Ensure that everyone has adequate, affordable health care coverage and receives culturally competent services and care

- Make health care services accessible and available in community, school, and clinical settings, including medical, dental, vision, mental health care, and long-term care
- Increase access to sex education and contraceptives in school, clinic, and community settings
- Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase literacy
- Provide culturally-sensitive care coordination and system navigation, including language interpretation and care tailored to patients' norms, beliefs, and values

Foster social connections within communities and cultivate empowered and civically engaged youth

- Establish positive relationships among youth and adult mentors and provide youth with leadership opportunities in schools, community groups, and local governments
- Create safe places to convene, such as community centers, with activities, programs, and supportive technologies for all ages and abilities
- Support information sharing, collaboration and networking to inform decision-making using social media and in-person approaches

To learn more about specific strategies that can support your work, visit **What Works for Health**, a living resource of evidence-informed policies and programs to make a difference locally. You can search for policies and programs that have been tested or implemented in communities like yours, or adapt strategies that have been tested elsewhere but seem like a good 'fit'. You can also learn about each strategy's likely impact on disparities.

Visit countyhealthrankings.org/whatworks



Communities Driving Local Change

We can work together to reshape the policies, programs, and practices that have marginalized some and, without action, will perpetuate health disparities. We can create environments where people are treated fairly, where everyone has a voice in decisions that affect them, and where all have a chance to succeed.

The 35 RWJF Culture of Health Prize winners are prime examples of making this a reality. For examples of how several communities, such as the below are cultivating a shared belief in good health for all, visit www.rwjf.org/prize.

- Columbia Gorge Region, OR/WA
- Richmond, VA
- Chelsea, MA
- Santa Monica, CA

Moving With Data to Action

County Health Rankings & Roadmaps offers a range of community supports including data, evidence, guidance and stories to support communities moving from awareness to action. Visit our website to learn more – countyhealthrankings.org.

- CHR&R provides a snapshot of a community's health and a starting point to explore ways to improve health and increase health equity. [Use the Data](#) will help you learn more about the data and find other sources as you begin to assess your needs and resources and focus on what's important.
- Our [Partner Center](#) helps changemakers in all sectors make connections and leverage collective power to put ideas into action.
- Our [Action Center](#) provides step-by-step guidance to help communities assess their needs, drive local policy and systems changes, and evaluate the impacts of their health improvement efforts. Our team of community coaches are available to communities across the nation to guide local collaborations and individuals to accelerate learning and action.

Guidance in the Action Center focuses on areas like:

- Working together is at the heart of making meaningful change. When people share a vision and commitment to improve health, it can yield better results than working alone. CHR&R's [Work Together](#) guide can help you build and sustain partnerships that reflect the diversity of your community. Together you can identify the challenges and solutions that can make a difference.
- Taking time to choose policies and programs that have been shown to work and that are a good fit for your community will maximize your chances of success. CHR&R's [Choose Effective Policies & Programs](#) guide can help you explore and select strategies to address priority issues.
- Once you have decided what you want to do, the next step is to make it happen. CHR&R's guide to [Act on What's Important](#) can help your community build on strengths, leverage available resources, and respond to unique needs.
- What you say and how you say it can motivate people to take the right action at the right time. CHR&R's [Communicate](#) guide can help you to develop strategic messages and deliver those messages effectively.

2018 County Health Rankings for the 87 Ranked Counties in Minnesota

| County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors |
|------------|-----------------|----------------|-------------------|-----------------|----------------|------------|-----------------|----------------|-----------------|-----------------|----------------|
| Aitkin | 77 | 79 | Fillmore | 8 | 19 | Martin | 53 | 64 | Rock | 45 | 13 |
| Anoka | 20 | 26 | Freeborn | 34 | 63 | McLeod | 27 | 31 | Roseau | 44 | 32 |
| Becker | 70 | 66 | Goodhue | 23 | 33 | Meeke | 26 | 34 | Scott | 2 | 4 |
| Beltrami | 86 | 86 | Grant | 66 | 62 | Mille Lacs | 80 | 80 | Sherburne | 13 | 9 |
| Benton | 58 | 56 | Hennepin | 37 | 21 | Morrison | 29 | 65 | Sibley | 21 | 55 |
| Big Stone | 40 | 37 | Houston | 19 | 15 | Mower | 56 | 67 | St. Louis | 74 | 69 |
| Blue Earth | 54 | 49 | Hubbard | 63 | 73 | Murray | 62 | 29 | Stearns | 32 | 17 |
| Brown | 16 | 7 | Isanti | 39 | 50 | Nicollet | 6 | 5 | Steele | 31 | 25 |
| Carlton | 76 | 60 | Itasca | 79 | 78 | Nobles | 25 | 74 | Stevens | 5 | 18 |
| Carver | 1 | 1 | Jackson | 41 | 14 | Norman | 78 | 57 | Swift | 12 | 59 |
| Cass | 85 | 85 | Kanabec | 43 | 81 | Olmsted | 14 | 3 | Todd | 38 | 76 |
| Chippewa | 59 | 52 | Kandiyohi | 28 | 41 | Otter Tail | 52 | 30 | Traverse | 36 | 36 |
| Chisago | 33 | 44 | Kittson | 42 | 42 | Pennington | 65 | 51 | Wabasha | 11 | 10 |
| Clay | 67 | 27 | Koochiching | 75 | 82 | Pine | 73 | 83 | Wadena | 83 | 72 |
| Clearwater | 84 | 84 | Lac qui Parle | 7 | 28 | Pipestone | 48 | 47 | Waseca | 15 | 40 |
| Cook | 82 | 35 | Lake | 71 | 24 | Polk | 72 | 77 | Washington | 3 | 2 |
| Cottonwood | 69 | 75 | Lake of the Woods | 47 | 71 | Pope | 51 | 16 | Watonwan | 49 | 68 |
| Crow Wing | 61 | 58 | Le Sueur | 22 | 45 | Ramsey | 68 | 54 | Wilkin | 50 | 20 |
| Dakota | 18 | 8 | Lincoln | 46 | 22 | Red Lake | 9 | 70 | Winona | 35 | 46 |
| Dodge | 4 | 6 | Lyon | 30 | 23 | Redwood | 81 | 61 | Wright | 10 | 11 |
| Douglas | 55 | 12 | Mahnomen | 87 | 87 | Renville | 64 | 53 | Yellow Medicine | 60 | 39 |
| Faribault | 57 | 43 | Marshall | 17 | 48 | Rice | 24 | 38 | | | |



Stay Up-To-Date with County Health Rankings & Roadmaps

For the latest updates on our Rankings, community support, RWJF Culture of Health Prize communities, and more visit countyhealthrankings.org/news. You can see what we're featuring on our webinar series, what communities are doing to improve health, and how you can get involved!

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that “race” is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 15. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under [Rankings Methods](#).

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit [What Works for Health](#).

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that “darker is bad”.
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

2018 County Health Rankings for Minnesota: Measures and National/State Results

| Measure | Description | US | MN | MN Minimum | MN Maximum |
|--------------------------------------|--|---------|---------|---------------|---------------|
| HEALTH OUTCOMES | | | | | |
| Premature death | Years of potential life lost before age 75 per 100,000 population | 6,700 | 5,100 | 3,100 | 12,900 |
| Poor or fair health | % of adults reporting fair or poor health | 16% | 12% | 9% | 21% |
| Poor physical health days | Average # of physically unhealthy days reported in past 30 days | 3.7 | 3.0 | 2.4 | 4.6 |
| Poor mental health days | Average # of mentally unhealthy days reported in past 30 days | 3.8 | 3.2 | 2.6 | 4.3 |
| Low birthweight | % of live births with low birthweight (< 2500 grams) | 8% | 6% | 3% | 8% |
| HEALTH FACTORS | | | | | |
| HEALTH BEHAVIORS | | | | | |
| Adult smoking | % of adults who are current smokers | 17% | 15% | 12% | 24% |
| Adult obesity | % of adults that report a BMI ≥ 30 | 28% | 27% | 22% | 37% |
| Food environment index | Index of factors that contribute to a healthy food environment, (0-10) | 7.7 | 8.9 | 6.2 | 9.6 |
| Physical inactivity | % of adults aged 20 and over reporting no leisure-time physical activity | 23% | 20% | 16% | 33% |
| Access to exercise opportunities | % of population with adequate access to locations for physical activity | 83% | 88% | 30% | 100% |
| Excessive drinking | % of adults reporting binge or heavy drinking | 18% | 23% | 19% | 26% |
| Alcohol-impaired driving deaths | % of driving deaths with alcohol involvement | 29% | 30% | 0% | 100% |
| Sexually transmitted infections | # of newly diagnosed chlamydia cases per 100,000 population | 478.8 | 389.3 | 42.7 | 853.8 |
| Teen births | # of births per 1,000 female population ages 15-19 | 27 | 17 | 6 | 76 |
| CLINICAL CARE | | | | | |
| Uninsured | % of population under age 65 without health insurance | 11% | 5% | 3% | 10% |
| Primary care physicians | Ratio of population to primary care physicians | 1,320:1 | 1,110:1 | 9,220:1 | 440:1 |
| Dentists | Ratio of population to dentists | 1,480:1 | 1,440:1 | 5,960:1 | 1,010:1 |
| Mental health providers | Ratio of population to mental health providers | 470:1 | 470:1 | 21,270:1 | 270:1 |
| Preventable hospital stays | # of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees | 49 | 37 | 24 | 77 |
| Diabetes monitoring | % of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring | 85% | 88% | 66% | 98% |
| Mammography screening | % of female Medicare enrollees ages 67-69 that receive mammography screening | 63% | 65% | 52% | 85% |
| SOCIAL AND ECONOMIC FACTORS | | | | | |
| High school graduation | % of ninth-grade cohort that graduates in four years | 83% | 83% | 53% | 97% |
| Some college | % of adults ages 25-44 with some post-secondary education | 65% | 74% | 46% | 83% |
| Unemployment | % of population aged 16 and older unemployed but seeking work | 4.9% | 3.9% | 2.3% | 9.6% |
| Children in poverty | % of children under age 18 in poverty | 20% | 13% | 4% | 30% |
| Income inequality | Ratio of household income at the 80th percentile to income at the 20th percentile | 5 | 4.4 | 3.2 | 5.3 |
| Children in single-parent households | % of children that live in a household headed by a single parent | 34% | 28% | 15% | 53% |
| Social associations | # of membership associations per 10,000 population | 9.3 | 13.0 | 7.1 | 42.8 |
| Violent crime | # of reported violent crime offenses per 100,000 population | 380 | 231 | 0 | 919 |
| Injury deaths | # of deaths due to injury per 100,000 population | 65 | 62 | 37 | 124 |
| PHYSICAL ENVIRONMENT | | | | | |
| Air pollution – particulate matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) | 8.7 | 9.3 | 6.4 | 11.7 |
| Drinking water violations | Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation. | NA | NA | No | Yes |
| Severe housing problems | % of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities | 19% | 14% | 7% | 19% |
| Driving alone to work | % of workforce that drives alone to work | 76% | 78% | 66% | 86% |
| Long commute – driving alone | Among workers who commute in their car alone, % commuting > 30 minutes | 35% | 30% | 10% | 54% |

2018 County Health Rankings: Ranked Measure Sources and Years of Data

| | Measure | Source | Years of Data |
|------------------------------------|--------------------------------------|---|---------------|
| HEALTH OUTCOMES | | | |
| Length of Life | Premature death | National Center for Health Statistics – Mortality files | 2013-2015 |
| Quality of Life | Poor or fair health | Behavioral Risk Factor Surveillance System | 2016 |
| | Poor physical health days | Behavioral Risk Factor Surveillance System | 2016 |
| | Poor mental health days | Behavioral Risk Factor Surveillance System | 2016 |
| | Low birthweight | National Center for Health Statistics – Natality files | 2010-2016 |
| HEALTH FACTORS | | | |
| HEALTH BEHAVIORS | | | |
| Tobacco Use | Adult smoking | Behavioral Risk Factor Surveillance System | 2016 |
| Diet and Exercise | Adult obesity | CDC Diabetes Interactive Atlas | 2014 |
| | Food environment index | USDA Food Environment Atlas, Map the Meal Gap | 2015 |
| | Physical inactivity | CDC Diabetes Interactive Atlas | 2014 |
| | Access to exercise opportunities | Business Analyst, Delorme map data, ESRI, & US Census Files | 2010 & 2016 |
| Alcohol and Drug Use | Excessive drinking | Behavioral Risk Factor Surveillance System | 2016 |
| | Alcohol-impaired driving deaths | Fatality Analysis Reporting System | 2012-2016 |
| Sexual Activity | Sexually transmitted infections | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | 2015 |
| | Teen births | National Center for Health Statistics – Natality files | 2010-2016 |
| CLINICAL CARE | | | |
| Access to Care | Uninsured | Small Area Health Insurance Estimates | 2015 |
| | Primary care physicians | Area Health Resource File/American Medical Association | 2015 |
| | Dentists | Area Health Resource File/National Provider Identification file | 2016 |
| | Mental health providers | CMS, National Provider Identification file | 2017 |
| Quality of Care | Preventable hospital stays | Dartmouth Atlas of Health Care | 2015 |
| | Diabetes monitoring | Dartmouth Atlas of Health Care | 2014 |
| | Mammography screening | Dartmouth Atlas of Health Care | 2014 |
| SOCIAL AND ECONOMIC FACTORS | | | |
| Education | High school graduation | ED Facts | 2014-2015 |
| | Some college | American Community Survey | 2012-2016 |
| Employment | Unemployment | Bureau of Labor Statistics | 2016 |
| Income | Children in poverty | Small Area Income and Poverty Estimates | 2016 |
| | Income inequality | American Community Survey | 2012-2016 |
| Family and Social Support | Children in single-parent households | American Community Survey | 2012-2016 |
| | Social associations | County Business Patterns | 2015 |
| Community Safety | Violent crime | Uniform Crime Reporting – FBI | 2012-2014 |
| | Injury deaths | CDC WONDER mortality data | 2012-2016 |
| PHYSICAL ENVIRONMENT | | | |
| Air and Water Quality | Air pollution – particulate matter* | Environmental Public Health Tracking Network | 2012 |
| | Drinking water violations | Safe Drinking Water Information System | 2016 |
| Housing and Transit | Severe housing problems | Comprehensive Housing Affordability Strategy (CHAS) data | 2010-2014 |
| | Driving alone to work | American Community Survey | 2012-2016 |
| | Long commute – driving alone | American Community Survey | 2012-2016 |

*Not available for AK and HI.

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