

**County Health
Rankings & Roadmaps**

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

2015 *County Health Rankings* **Key Findings 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

The *County Health Rankings & Roadmaps* program helps communities identify and implement solutions that make it easier for people to be healthy in their neighborhoods, schools, and workplaces. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what is keeping people healthy or making people sick. The *Roadmaps* show what we can do to create healthier places to live, learn, work, and play. 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.

This document includes answers to the following questions:

- A. How Healthy Are Our Nation’s Counties? (page 2)
- B. Are Our Nation’s Counties Getting Healthier? (page 3)
- C. What Makes a Healthy County? (page 4)
- D. A Focus on Social and Economic Factors (pages 5-8):
 - a. Income and Poverty
 - b. Income Inequality
 - c. Employment
 - d. Community Safety
- E. National Results (page 9)
- F. Measures and Data Sources (page 10)

DO THE 2015 COUNTY HEALTH RANKINGS INCLUDE DATA FOR 2015?

2015 reflects the year of release, not the year of the data. We use the most recent data available for each measure. The year(s) represented varies from measure to measure, depending on the data available at the time of release. For example, when we released the 2010 *Rankings*, the most recent data available for premature death was for 2004-2006. For the 2015 *Rankings*, the most recent data available for this same measure was for 2010-2012. The data sources and years for each measure are listed on page 10.

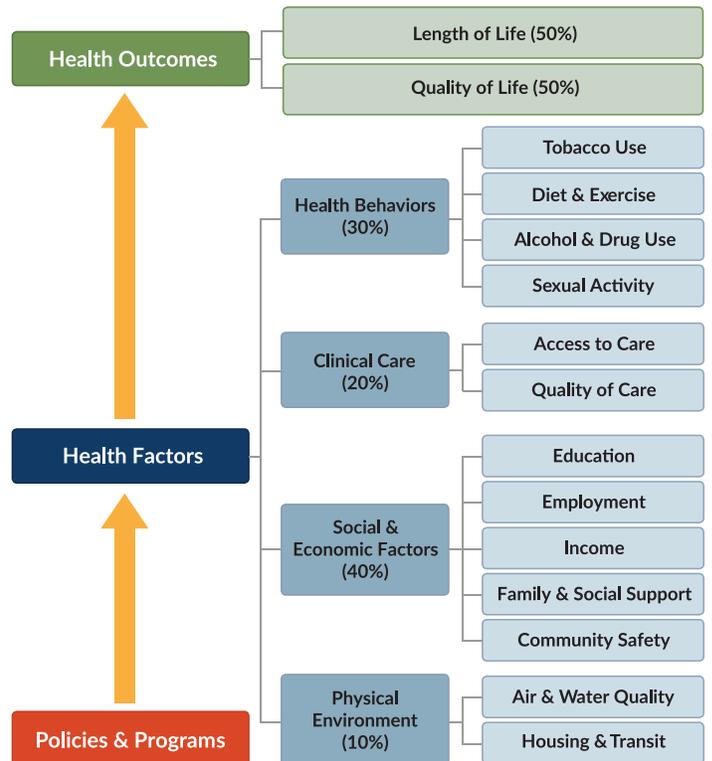
Now in its sixth year, the *County Health Rankings* continues to bring actionable data to communities across the nation. Based on the *County Health Rankings* model, the *Rankings* are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health. They have been used to bring together government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public to advance local health improvement solutions.

We compile the *Rankings* using county-level measures from a variety of national data sources which can be found on page 10. These measures are standardized and combined using scientifically-informed weights. We then rank counties within each state, providing two overall ranks:

1. **Health outcomes:** how healthy is a county now?
2. **Health factors:** how healthy will a county be in the future?

We report these ranks at countyhealthrankings.org, along with all the underlying measures for this year and prior years. We also provide tools to help communities use their data to identify opportunities for improvement and guidance to help them take action toward improving their health.

County Health Rankings Model



County Health Rankings model © 2014 UWPHI

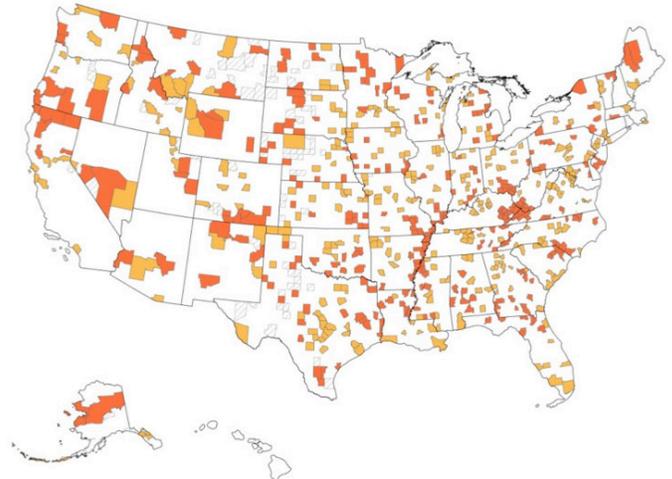
countyhealthrankings.org

HOW HEALTHY ARE OUR NATION'S COUNTIES?

In 2015, we ranked the health of 3,061 of 3,143 counties (or county equivalents) in the US. We rank the “health outcomes” of counties within each state—not across states. To do this, we look at how long people live and how healthy they feel. The 2015 Health Outcomes map shows the counties that were ranked in the top 10 percent in 2015 (in light orange) for health outcomes within their state and those ranked in the bottom 10 percent (in dark orange).

Since we began ranking the health of counties nationwide in 2010, some counties have remained at the same rank within their state while others have gone up or down.

- 159 counties ranked among the top 10 percent **within their state** for all six years of the *County Health Rankings*.
- 129 counties ranked among the bottom 10 percent **within their state** for all six years of the *County Health Rankings*.



2015 Health Outcomes

■ Least Healthy ■ Most Healthy ▨ Unranked County

MEASURING PROGRESS

A county's rank tells a community how healthy it is today compared to other counties in its state. Ranks get people's attention and are a call to action but they do not fully capture progress. A county's rank could actually get worse even though its health is getting better.

For example, the premature death rate for Bexar County in Texas (home to San Antonio) improved by 6 percent from our initial 2010 *Rankings* to 2015 while its rank for length of life dropped by 8 places (from 58 to 66). People are living longer lives in Bexar but its rate of improvement has not been as great as that of other counties in Texas. As a result, its rank, relative to the other counties, has gone down.

As this example shows, an individual county's rank does not always tell the full story. Instead, we need to examine specific measures, such as premature death. For more guidance on measuring progress, visit www.countyhealthrankings.org/measuring-progress.

WHAT'S THE HEALTHIEST/LEAST HEALTHY COUNTY IN THE UNITED STATES?

The purpose of the *County Health Rankings* is to serve as a call to action to improve health within **all** states and local communities by comparing counties within states and highlighting their differences in health. Identifying the healthiest or least healthy county in the United States would not serve this purpose. However, the *Rankings* do include data on top performing counties across the nation for each of the 35 measures (see page 10), so communities can see how they compare to other counties in their state and how they compare to these top performing counties in the nation.

HOW DO WE MEASURE HOW HEALTHY WE ARE?

When we look at how long people live, we examine what we call “premature death”, i.e., deaths before age 75, since many of these deaths are preventable. Specifically, we look at the years of life lost so that deaths at an earlier age are given more weight than deaths among those closer to age 75.

To estimate how healthy people feel, we use measures of people's reported health status and how often they feel healthy each month. And, our final measure of health outcomes gauges the share of a community's youngest members that have an unhealthy start to life: we look at the percent of babies born with low birthweight.

ARE OUR NATION'S COUNTIES GETTING HEALTHIER?

Premature death is the single most important health outcome that we measure and is given the highest weight in our calculations. Premature death rates have been slowly and steadily declining across the nation. Over 60 percent of counties have seen some level of improvement in premature death between 2004-2006 and 2010-2012. However, in some counties, it is not easy to tell whether sustained improvements in premature death have occurred because death rates can fluctuate a lot when population sizes are small. Among our nation's largest counties or county equivalents (those above 65,000 population) where we can identify significant improvement, the District of Columbia has seen the greatest improvement in premature death since the 2010 *Rankings*, decreasing by 31 percent: from an age-adjusted rate of 12,009 years of potential life lost (YPLL) under age 75 per 100,000 in 2004-2006 to a rate of 8,239 per 100,000 in 2010-2012. With a population of approximately 600,000, this means that the annual number of YPLL has dropped from about 72,000 to 48,000.

Example of How Years of Potential Life Lost (YPLL) Under Age 75 Are Calculated For Each County

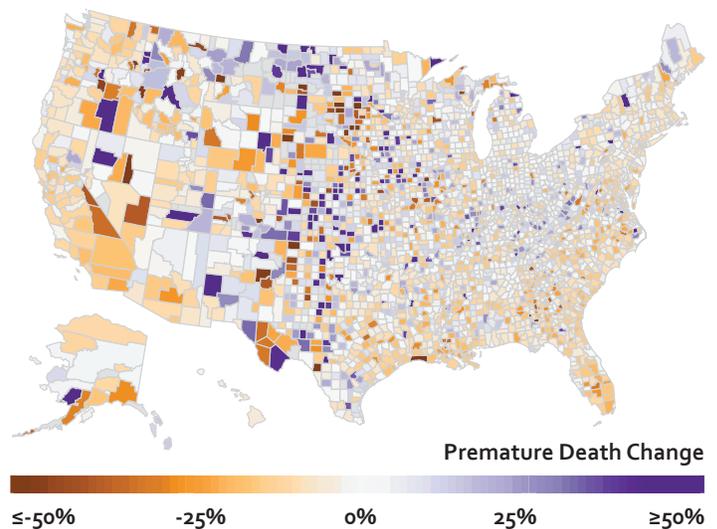
Age Group	Years of Life Lost for each Death	Deaths Per Year	Total YPLL Per Year
1 year	74.5 x	101 =	7525
1-4 years	72.5 x	9 =	677
5-9 years	67.5 x	6 =	405
10-14 years	62.5 x	11 =	688
15-19 years	57.5 x	43 =	2473
20-24 years	52.5 x	64 =	3378
25-34 years	45 x	156 =	7035
35-44 years	35 x	302 =	10570
45-54 years	25 x	623 =	15575
55-64 years	15 x	734 =	11010
65-74 years	5 x	866 =	4332
Total		2,916	63,665

63,665 years of potential life (YPLL) were lost in this community. To allow comparisons across counties of different sizes, we report on rates per 100,000. So, for a community with a population of 535,000, the YPLL per 100,000 population = $63,665 / 535,000 * 100,000 = 11,900$.

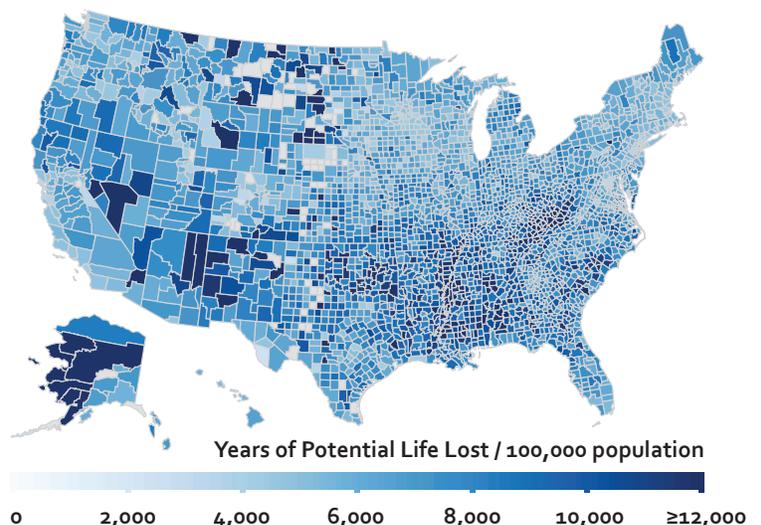
Greatest decrease in premature death (>65,000 population):

1. District of Columbia
2. Madison County, Mississippi
3. Pinal County, Arizona
4. Martin County, Florida
5. Albemarle County, Virginia
6. Imperial County, California
7. Baltimore City, Maryland
8. Orleans Parish, Louisiana
9. New York County, New York
10. Fulton County, Georgia

Change (%) in Premature Death Between 2010 and 2015 County Health Rankings



Current Premature Death (2015 County Health Rankings)



WHAT MAKES A HEALTHY COUNTY?

In the *Rankings*, we examine four types of health factors that influence the health of a county: health behaviors, clinical care, social and economic, and physical environment. In turn, each of these factors is based on several measures—the full list of factors and measures is provided on page 9. A fifth set of factors that influence health (genetics and biology) is not included since these factors cannot be changed through community action.

We identified the counties that ranked in the top (Healthiest) and bottom (Unhealthiest) 10 percent for health outcomes in each state and then compared the average performance of this subset of counties for each of these four types of health factors. We highlight here some key differences between the healthiest and unhealthiest counties on the right. For example, on average, the top 10 percent (Healthiest) counties in each state have higher college attendance and high school graduation rates than the bottom 10 percent (Unhealthiest).

Social and economic factors are particularly important, contributing more toward health outcomes than any other group of factors. We describe some of these key measures, including our new income inequality measure, on the next four pages.

NEED HELP IN YOUR COMMUNITY? CALL A COACH!

The *Roadmaps to Health* Action Center is a one-stop shop for information to help community members or leaders who want to improve their community's health by addressing factors that we know influence health, such as education, income, and community safety. The Action Center has 11 community coaches, located across the nation, who provide customized consultation to local leaders who have requested guidance in how to accelerate their efforts to improve health. You can contact a coach by activating the Get Help button at countyhealthrankings.org.

SOCIAL & ECONOMIC FACTORS	HEALTHIEST COUNTIES	UNHEALTHIEST COUNTIES
Education 	Higher college attendance	Lower high school graduation rates
Employment 	6% of adults are unemployed	9% of adults are unemployed
Income 	Fewer children living in poverty	Higher income inequality
Family & Social Support 	25% of children live in single-parent households	38% of children live in single-parent households
Community Safety 	Less violent crime	More deaths due to injuries
HEALTH BEHAVIORS	HEALTHIEST COUNTIES	UNHEALTHIEST COUNTIES
Tobacco Use 	16% of adults smoke	25% of adults smoke
Diet & Exercise 	76% of population has easy access to exercise opportunities	58% of population has easy access to exercise opportunities
Alcohol & Drug Use 	29% of car crash deaths involve alcohol	31% of car crash deaths involve alcohol
Sexual Activity 	Fewer sexually transmitted infections	Teen birth rate twice as high
CLINICAL CARE	HEALTHIEST COUNTIES	UNHEALTHIEST COUNTIES
Access to Care 	More access to primary care physicians, dentists and mental health providers	More uninsured adults
Quality of Care 	Fewer preventable hospital stays	Lower mammogram rates
PHYSICAL ENVIRONMENT	HEALTHIEST COUNTIES	UNHEALTHIEST COUNTIES
Air & Water Quality 	Better air and water quality	Worse air and water quality
Housing & Transit 	Fewer households have housing problems	More households have housing problems

A FOCUS ON SOCIAL AND ECONOMIC FACTORS

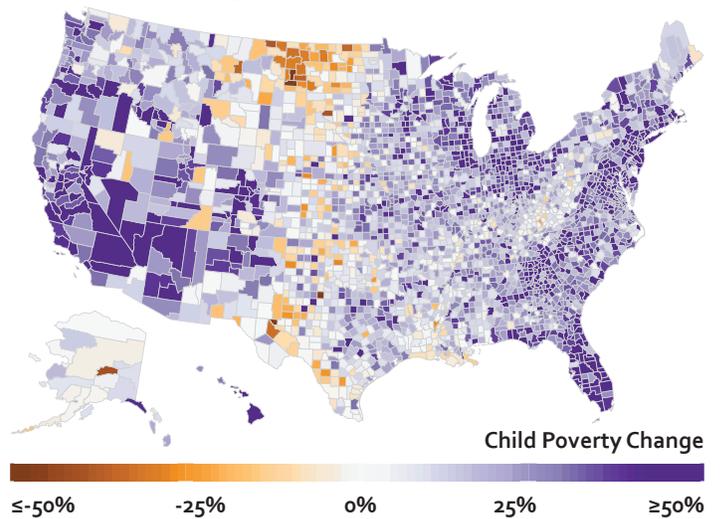
The average level of income across households in our nation's counties and its relative distribution are both important to health and wellbeing. Since children are particularly vulnerable to the adverse effects of the lack of income, we report on the percent of children in poverty. In addition, we encourage communities to examine our new data on income inequality that highlight significant within-county differences, even in communities where fewer people live in poverty. We also examine employment, a key pathway to reducing poverty, and community safety.

Income and Poverty

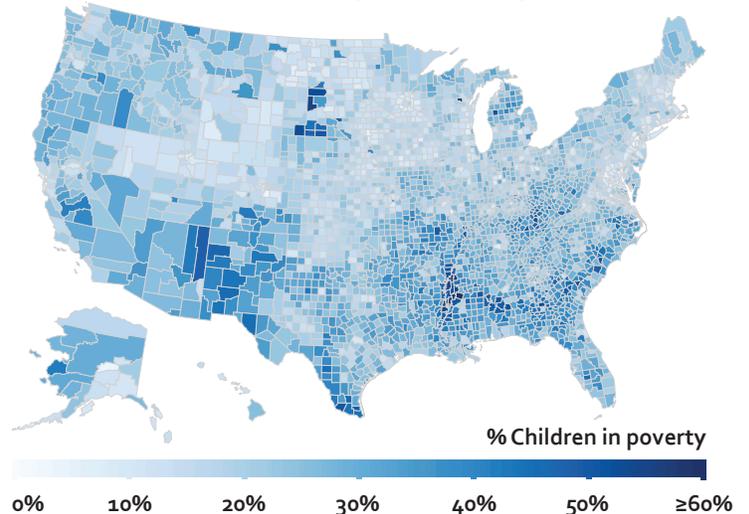
Household income shapes our choices about housing, education, child care, food, medical care, and more. Wealth, the accumulation of savings and assets, helps protect us in times of economic distress. As income and wealth increase or decrease, so does health status. For some, income comes from jobs and wealth (or savings and investments), for others - the government provides supports. Income allows families and individuals to purchase health insurance and medical care, but also provides options for healthy lifestyle choices. Poorer families and individuals are more likely to live in inadequate housing in unsafe neighborhoods, often with limited access to healthy foods, employment options, and quality schools. While the starkest difference in health is between those with the highest and lowest incomes, this relationship persists throughout all income brackets. The ongoing stress and challenges associated with poverty can lead to cumulative health damage, both physical and mental.

- Among counties in the US, the average rate of children living in poverty was 24 percent in 2013.
- Rates of children in poverty are more than twice as high in the unhealthiest counties in each state as they are in the healthiest counties.
- The percentage of children living in poverty in US counties ranges from 3 percent to 65 percent.
- The top performing counties in the US (the 10 percent with the lowest rates of child poverty) have child poverty rates of less than 13 percent.
- The worst performing counties (the 10 percent with the highest rates of child poverty) have child poverty rates of at least 38 percent.
- Rates of children living in poverty are highest in counties in the Southwest and Southeast, as well as parts of Appalachia, the Mississippi Delta, and the Plains.

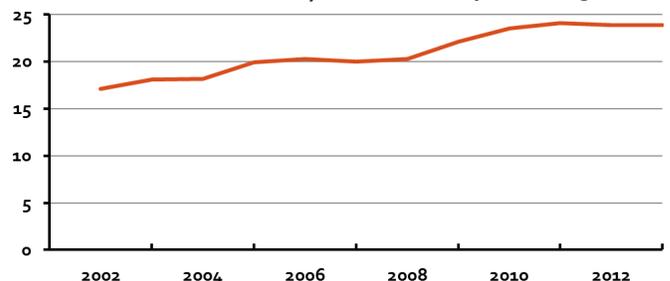
Change (%) in Child Poverty between 2010 and 2015
County Health Rankings



Current Child Poverty (2015 County Health Rankings)



Percent of Children in Poverty in US Counties, 2002-2013



STRATEGIES IN ACTION

In **Buncombe County, North Carolina**, Asheville's living wage ordinance, passed in May 2007, ensured that city employees were paid a living wage (\$12.50), and Buncombe County's policy passed in 2012. Though state law has limited some expansion of the living wage law, a voluntary certification program identifies and promotes local employers that pay a living wage. So far, more than 400 local businesses have been certified through this program, which has extended beyond Buncombe to several other North Carolina counties. The living wage campaign is being sustained through the creation of the membership organization, Just Economics, a voice for economic sustainability and justice in the region.

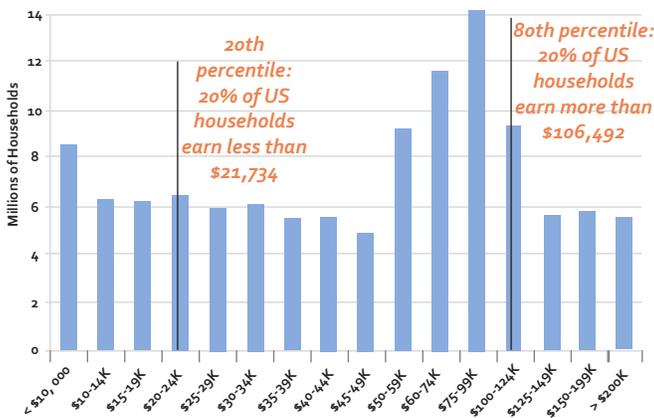
NEW THIS YEAR: INCOME INEQUALITY

Income inequality is a measure of the divide between the poor and the affluent. Income inequality in our communities affects how long and how well we live and is particularly harmful to the health of poorer individuals. Income inequality within US communities can have broad health impacts, including increased risk of mortality, poor health, and increased cardiovascular disease risks. Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience loss of social connections, or how we relate to one another, and decreases in trust or social support and sense of community for all residents.

Our new measure of **income inequality** within each county in the US compares household income at the 80th percentile level with that at the 20th percentile, i.e., if the 80th percentile for household income in a county is \$100,000 and the 20th percentile is \$20,000, then the income inequality ratio will be $\$100,000/\$20,000$ or 5.0. Meaning that on average, higher-income households have five times the income of lower-income households in that county.

- Within counties in the US, the average (median) income inequality ratio is 4.4.
- The income inequality ratio in US counties ranges from 2.6 to 9.6.
- The top performing counties in the US (the 10 percent with the lowest income inequality ratios) in the US have income inequality ratios of less than 3.7.
- The worst performing counties (the 10 percent with the highest income inequality ratios) have income inequality ratios of 5.4 or higher.
- Income inequality ratios are highest in counties with large metropolitan areas and those located in the Southeast and Southwest, as well as part of Appalachia and the Plains.

Distribution of Household Income Across the Nation



Potential Solutions for Poverty and Income Inequality

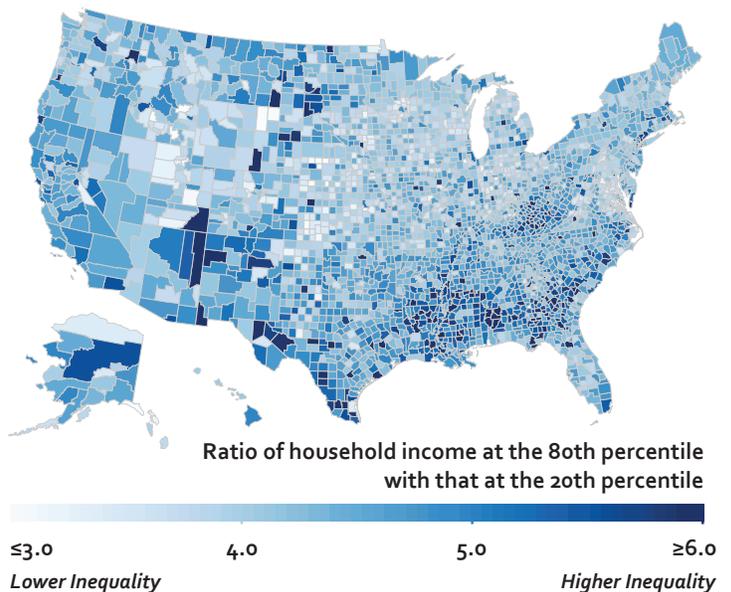
Communities can work together to reduce poverty and narrow the gap between the affluent and the poor by investing in policies, programs, and plans that give everyone the opportunity to be healthy and fully benefit from the factors, such as education, employment, or access to clinical care, which influence our health.

Based on the evidence, there are several general strategies to reduce poverty and income inequality:

- Invest in education to boost employment and career prospects by providing support for educational achievement from early childhood through adulthood.
- Invest in workforce development to improve job skills and promote labor market participation, fostering more and better career options.
- Increase public and private sector wages and enhance benefits for low-income earners by offering living wages and paid sick leave.
- Offer higher earned-income tax credits and help defray the cost of child care for working parents by expanding refundable child care tax credits and increasing child care subsidies.
- Promote and increase access to and efficiencies of public and private programs and services.

For information on specific strategies, visit What Works for Health at countyhealthrankings.org/roadmaps/what-works-for-health.

Current Income Inequality (2015 County Health Rankings)



STRATEGIES IN ACTION

To empower young people and expand educational opportunities to improve health, **Spokane County, Washington** is transforming its approach to student success. County leaders—including school officials, local universities, the business community and other partners—responded with a series of innovative steps, including full-day kindergarten; skill-building training for young students; a real-time system to monitor student attendance, behaviors, and grades; and the creation of Community Attendance Support Teams (CAST) with targeted dropout prevention programs designed to support and empower young people rather than focusing on punishment. And, as they improve student performance and graduation rates, they are partnering with business to create a stronger pipeline to better jobs.

EMPLOYMENT

Employment provides income and other benefits that can support healthy lifestyle choices. Unemployment and under employment limit these choices, and negatively affect both quality of life and health overall. Those who are unemployed face challenges to health and well-being, including lost income and, often, lack of health insurance. Compared to those who are employed, unemployed individuals are more likely to be in poor or fair health, and are more likely to suffer from increased stress, high blood pressure, heart disease, and depression.

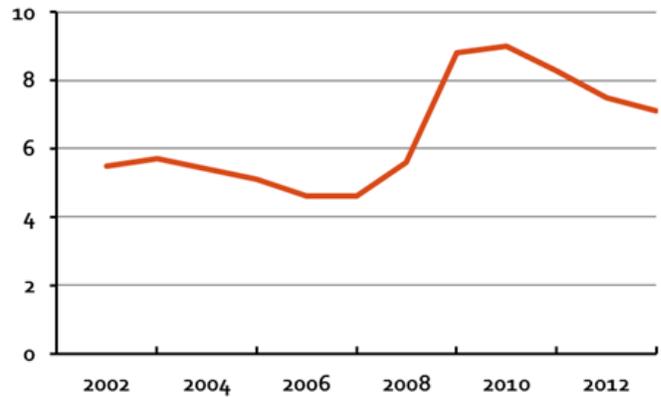
- Among counties in the US, the average rate of unemployment was 7.1 percent in 2013.
- Across the nation, rates of unemployment are 1.5 times as high in the least healthy counties of each state as they are in the healthiest counties.
- The unemployment rate in US counties ranges from 0.9 percent to 27.7 percent.
- The top performing counties in the US (the 10 percent with the lowest rates of unemployment) have unemployment rates of 4.1 percent or lower.
- The worst performing counties (the 10 percent with the highest unemployment) for unemployment have unemployment rates of 10.7 percent or higher.

Unlike other measures in the *County Health Rankings*, unemployment is cyclical in nature. The impact of the 2007-2009 recession shows up clearly in the graph of Unemployment in US Counties since 2002.

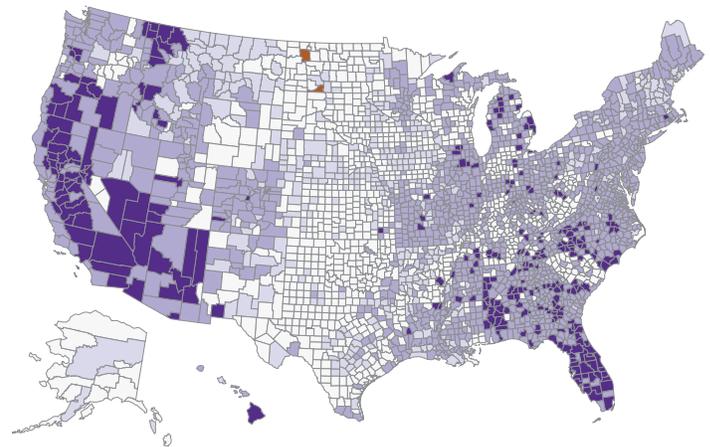
The maps show the counties hit hardest by the recession (Trends in Unemployment from 2006-2010) and the counties that have recovered the most since the recession (Trends in Unemployment from 2010 to 2013):

- During the recession, counties in the West, Southeast, and rust belt region of the US were hit hardest by growing unemployment.
- Since the recession, some counties in the West and the Southeast have shown the greatest reductions in unemployment.

Percent Unemployment in US Counties, 2002-2013



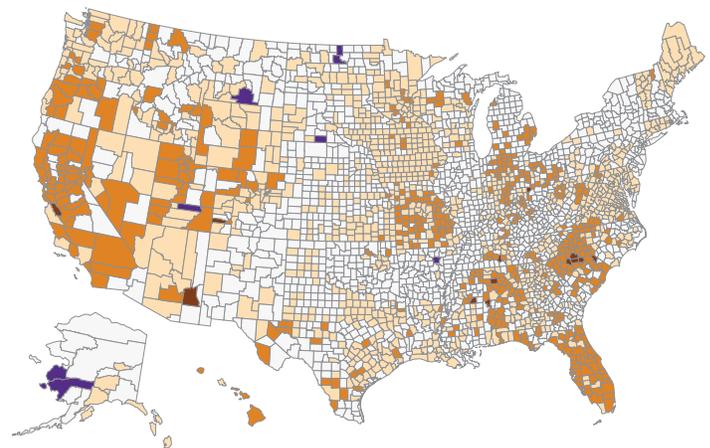
Trends in Unemployment from 2006 to 2010



Trends During Recession

- Decreasing unemployment
- No change
- Unemployment increased less than 1% per year
- Unemployment increased between 1% and 2% per year
- Unemployment increased by more than 2% per year

Trends in Unemployment from 2010 to 2013



Recovery

- Unemployment decreased by more than 2% per year
- Unemployment decreased between 1 & 2% per year
- Unemployment decreased less than 1% per year
- No Change
- Worsening unemployment

STRATEGIES IN ACTION

Business Development through Entrepreneurism in Williamson, West Virginia. This comprehensive framework is founded on efforts to broaden the community’s economic landscape. The Health Innovation Hub is an initiative in Williamson that includes ongoing opportunities for local entrepreneurs to “go public” with their ideas about new businesses and then links these entrepreneurs with seed money and expertise. Business ideas include new restaurants to serve healthy menu items, a community kitchen to aggregate and process locally grown foods, a marketing plan to attract tourists, a solar company to equip displaced workers with sustainable technology skills, and redevelopment initiatives (such as the Hatfield-McCoy Trails and the Sycamore Campground).

COMMUNITY SAFETY

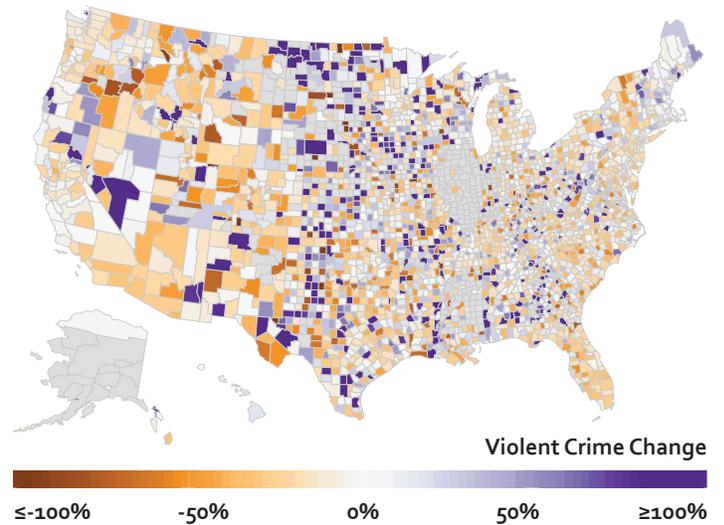
Injuries are the third leading cause of death in the US and the leading cause for those between the ages of one and 44. Injuries resulting from violent acts in neighborhoods and homes influence health and quality of life in the short and long-term, for those directly and indirectly affected.

- Among counties in the US, the average rate of violent crime was 199 per 100,000 population in 2010-2012.
- The rate of violent crimes in US counties ranges from 0 to 1,885 per 100,000 population.
- The top performing counties in the US (the 10 percent with the lowest rates of violent crime) have 59 or fewer reported violent crimes per 100,000 population.
- The worst performing US counties (the 10 percent with the highest rates of violent crime) have violent crime rates of 504 per 100,000 or greater.
- Rates of violent crime are highest in the Southwest, Southeast, and Mississippi Delta regions.

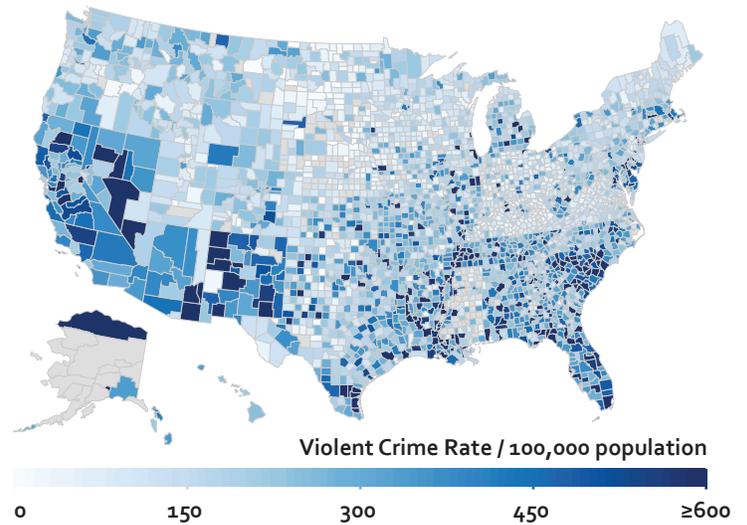
Potential Solutions to Reduce Violent Crime

- Community organizations, healthcare organizations, and government entities can invest in early childhood home visiting programs, where trained personnel visit parents and children in their homes to provide parents with information and training that supports healthy child development and helps prevent child abuse and maltreatment.
- Local residents can participate in neighborhood watches, working together to solve problems and reporting suspicious or potentially criminal behavior to police or a neighborhood coordinator.
- Community members can serve as mentors for at-risk youth, building personal relationships and helping to reduce delinquent behavior.
- Law enforcement and community agencies can use focused deterrence strategies to target a particular crime in a community. After identifying key offenders and behavior patterns, law enforcers use a varied menu of sanctions to stop offenders from continuing their violent behaviors while social and community resources are focused on the targeted offenders.

Change (%) in Violent Crime Between 2010 and 2015 County Health Rankings



Current Violent Crime (2015 County Health Rankings)



STRATEGIES IN ACTION

The Custody Alternatives Program (CAP) in **Santa Cruz County, California** is part of a partnership between the Sheriff and the community that provides community-based rehabilitation opportunities to people who have committed minor offenses. This successful, cost-effective alternative-to-incarceration program provides the individual with an opportunity to pursue community based education, employment, treatment, and social services to help those enrolled to get their lives back on track. CAP was supported by the community engagement efforts of Smart on Crime, a coalition of criminal justice professionals, elected officials, ACLU, and community members who with multiple community sponsors hosted a series of community forums to define local solutions for criminal justice reform. The success rate of CAP is over 90 percent and the program has saved the county over \$5 million dollars to date.

2015 COUNTY HEALTH RANKINGS: NATIONAL RESULTS

	Measure	Measure Description	Min. County Value	Max. County Value	Top ¹ Performers For Measure	US Average (Median)	Bottom ¹ Performers For Measure
Health Outcomes	Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	2,101	25,394	5,200	7,681	10,997
	Poor or fair health	% of adults reporting fair or poor health (age-adjusted)	4%	51%	10%	17%	26%
	Poor physical health days	Average # of physically unhealthy days reported in past 30 days (age-adjusted)	1.1	10	2.5	3.7	5.2
	Poor mental health days	Average # of mentally unhealthy days reported in past 30 days (age-adjusted)	1	10.1	2.3	3.5	4.9
	Low birthweight	% of live births with low birthweight (< 2500 grams)	3%	23%	6%	8%	11%
Health Behaviors	Adult smoking	% of adults who are current smokers	3%	51%	14%	21%	29%
	Adult obesity	% of adults that report a BMI of 30 or more	12%	48%	25%	31%	36%
	Food environment index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	0	10	8.4*	7.3	5.5
	Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	9%	43%	20%	27%	34%
	Access to exercise opportunities	% of population with adequate access to locations for physical activity	0%	100%	92%*	65%	31%
	Excessive drinking	% of adults reporting binge or heavy drinking	3%	56%	10%	16%	23%
	Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	0%	100%	14%	31%	50%
	Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	39.2	2854.3	138.2	290.8	691.6
Clinical Care	Teen births	# of births per 1,000 female population, ages 15-19	4.1	128.0	19.5	41.5	69.5
	Uninsured	% of population under age 65 without health insurance	3%	42%	11%	17%	25%
	Primary care physicians	Ratio of population to primary care physicians	210:1	20,936:1	1,045:1	2,015:1	5,277:1
	Dentists	Ratio of population to dentists	279:1	28,057:1	1,377:1	2,670:1	7,529:1
	Mental health providers	Ratio of population to mental health providers	70:1	52,617:1	386:1	1,128:1	5,875:1
	Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	15.4	267.8	41.2	65.3	103.4
	Diabetic monitoring	% of diabetic Medicare enrollees, ages 65-75, that receive HbA1c monitoring	12%	100%	90%*	85%	78%
Social and Economic Factors	Mammography screening	% of female Medicare enrollees, ages 67-69, that receive mammography screening	24%	84%	71%*	61%	50%
	High school graduation	% of ninth-grade cohort that graduates in four years	20%	100%	93%*	85%	71%
	Some college	% of adults ages 25-44 with some post-secondary education	3%	100%	71%*	56%	41%
	Unemployment	% of population ages 16 and older unemployed but seeking work	1%	28%	4%	7%	11%
	Children in poverty	% of children under age 18 in poverty	3%	65%	13%	24%	38%
	Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	2.6	9.6	3.7	4.4	5.4
	Children in single-parent households	% of children that live in a household headed by single parent	0%	100%	20%	31%	45%
	Social associations	# of associations per 10,000 population	0	82.5	22.0*	12.6	6.9
	Violent crime	# of reported violent crime offenses per 100,000 population	0	1885	59	199	504
Physical Environment	Injury deaths	# of deaths due to injury per 100,000 population	23.7	257.6	50.1	73.8	109.0
	Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM _{2.5})	7.2	14.9	9.5	11.9	13.4
	Drinking water violations	% of population potentially exposed to water exceeding a violation limit during the past year	0%	100%	0%	1%	31%
	Severe housing problems	% of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	0%	71%	9%	14%	20%
	Driving alone to work	% of the workforce that drives alone to work	5%	95%	71%	80%	85%
Long commute - driving alone	Among workers who commute in their car alone, the % that commute more than 30 minutes	0%	71%	15%	29%	47%	

¹ Top Performers represent the 10th percentile, i.e., the point at which only 10% of counties are doing better, and Bottom Performers the 90th percentile. A higher value usually represents worse performance but for some measures (*), higher values are better and so the Top Performers represent the 90th percentile.

2015 COUNTY HEALTH RANKINGS: DATA SOURCES AND YEARS OF DATA

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2010-2012
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2006-2012
	Poor physical health days	Behavioral Risk Factor Surveillance System	2006-2012
	Poor mental health days	Behavioral Risk Factor Surveillance System	2006-2012
	Low birthweight	National Center for Health Statistics – Natality files	2006-2012
HEALTH FACTORS			
Health Behaviors			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2006-2012
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2011
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2012
	Physical inactivity	CDC Diabetes Interactive Atlas	2011
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2013
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2006-2012
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2009-2013
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2012
	Teen births	National Center for Health Statistics - Natality files	2006-2012
Clinical Care			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2012
	Primary care physicians	Area Health Resource File/American Medical Association	2012
	Dentists	Area Health Resource File/National Provider Identification file	2013
	Mental health providers	CMS, National Provider Identification file	2014
Quality of Care	Preventable hospital stays	Dartmouth Atlas of Health Care	2012
	Diabetic monitoring	Dartmouth Atlas of Health Care	2012
	Mammography screening	Dartmouth Atlas of Health Care	2012
Social and Economic Factors			
Education	High school graduation	data.gov, supplemented w/ National Center for Education Statistics	2011-2012
	Some college	American Community Survey	2009-2013
Employment	Unemployment	Bureau of Labor Statistics	2013
Income	Children in poverty	Small Area Income and Poverty Estimates	2013
	Income inequality	American Community Survey	2009-2013
Family and Social Support	Children in single-parent households	American Community Survey	2009-2013
	Social associations	County Business Patterns	2012
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2010-2012
	Injury deaths	CDC WONDER mortality data	2008-2012
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution - particulate matter ¹	CDC WONDER environmental data	2011
	Drinking water violations	Safe Drinking Water Information System	FY2013-14
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2007-2011
	Driving alone to work	American Community Survey	2009-2013
	Long commute – driving alone	American Community Survey	2009-2013

¹ Not available for AK and HI.

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

University of Wisconsin Population Health Institute
610 Walnut St, #524, Madison, WI 53726
(608) 265-8240 / info@countyhealthrankings.org

Credits

The *County Health Rankings & Roadmaps* program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Institute

RECOMMENDED CITATION:

University of Wisconsin Population Health Institute. *County Health Rankings* Key Findings Report 2015.

LEAD AUTHORS:

Bridget Catlin, MHSA, PhD
Amanda Jovaag, MS
Julie Willems Van Dijk, RN, PhD

This publication would not have been possible without the following contributions:

RESEARCH ASSISTANCE

Alison Bergum, MPA
Marjory Givens, PhD, MSPH
Kathryn Hatchell
Hyojun Park, MS
Elizabeth Pollock
Matthew Rodock, MPH
Anne Roubal, MS

OUTREACH ASSISTANCE

Mary Bennett, MFA
Matthew Call
Kitty Jerome, MA
Stephanie Johnson, MSW
Kate Konkle, MPH
Jan O'Neill, MPA

COMMUNICATIONS AND WEBSITE DEVELOPMENT

Burness
Forum One

DATA:

Centers for Disease Control and Prevention: National Center for Health Statistics
Dartmouth Institute for Health Policy & Clinical Practice

ROBERT WOOD JOHNSON FOUNDATION:

Abbey Cofsky, MPH
Andrea Ducas, MPH
Michelle Larkin, JD, MS, RN
James S. Marks, MD, MPH
Joe Marx
Donald Schwarz, MD, MPH
Kathryn Wehr, MPH

SCIENTIFIC ADVISORY GROUP:

Patrick Remington, MD, MPH, Chair
Maureen Bisognano, MS
Bridget Catlin, MHSA, PhD
Tom Eckstein, MBA
Elizabeth Mitchell
C. Tracy Orleans, PhD

Renée Canady, PhD, MPA
Ana Diez Roux, MD, PhD
Wayne Giles, MD, MS
Ali Mokdad, PhD
Steven Teutsch, MD, MPH