QUESTIONS AND ANSWERS FROM THE FEBRUARY 2015 METHODS AND MEASURES WEBINAR

2015 Measures and Tools:

What are the changes in measures, display, and tools?

- There are only two measure changes in 2015: 1) Income inequality is new under Social and Economic Factors; 2) our measure of social associations replaces inadequate social support under Family and Social Support.
- The maps we use to display *measure* data will have a different look. In past releases, we separated each state's values for a measure into quartiles with the same number of counties in each quartile for display in our maps. However, this year, to better highlight the magnitude of differences within states, we are displaying more of the spectrum of values in a state.
- We have reorganized the section on *Using the Rankings Data* on our website, and introduced new content providing measure-by-measure guidance on how you can explore our measures by race, age, gender or even by smaller geographic areas within counties. For example, you'll see how to access county-by-county quality of care data organized by racial groups, or how to calculate the rate of children in single-parent households for census tracts in your community.
- Finally, there are now 11 *Roadmaps* community coaches working across the country. Seven new coaches joined the *CHR&R* team and are based in locations across the U.S.. In addition, we have improved the *Roadmaps to Health* Action Center to make it easier to use.

Have the new measures affected the Rankings this year?

We are continuing to use the same measures (with updated years where available) for Health Outcomes. For the Health Factors, although we revised a few measures, our analysis shows no more change in Health Factor ranks than in previous years. This is due in part to the relatively small weights that are assigned to most individual measures. As communities look to understand their ranks, they should examine the underlying measures and changes in their rates from year to year.

Do you plan to add more data sources/metrics?

We are always looking for opportunities to improve our measures and to provide meaningful data to local communities taking action. During 2014, we added a 12-member Scientific Advisory Group, made up of nationally recognized leaders in population health research, methods, and research translation. This group is helping guide decision-making about additions or modifications to *Rankings* measures.

Why measure adult obesity and tobacco use rather than child obesity and tobacco use, which are major areas of concern across the country?

We would love to include measures of obesity and tobacco use among children or adolescents in the *County Health Rankings*. However, to our knowledge, a county-level source for this data that is available across the country does not currently exist.

2015 Methods

How are the Rankings calculated?

The *County Health Rankings* are compiled from many different types of data. To calculate the ranks, we first standardize each of the measures. The ranks are then calculated based on weighted sums of these of the standardized measures within each state. The county with the lowest score (best health) gets a rank of #1 for that state and the county with the highest score (worst health) is assigned a rank corresponding to the number of places we rank in that state. Visit our website page "Rankings Methods" to learn more.

Are County Health Rankings measures age-adjusted?

Age-adjustment is a useful strategy to increase the comparability of health measures between counties. However, it can also mask the true burden of a health need in a county. Due to these considerations, only some measures in the *Rankings* are age-adjusted. The following Health Outcome measures are age-adjusted: premature death (YPLL), self-reported health, physically unhealthy days, and mentally unhealthy days. Preventable hospital stays are also age-adjusted.

What measures can we track over time or across regions?

There are currently twelve measures with trend data available (premature death, preventable hospital stays, diabetic screening, mammography, sexually transmitted infections, unemployment, air pollution, children in poverty, uninsured, violent crime, physical inactivity, and obesity). There are at least three types of questions you will want to consider for each of these measures:

1. Is your county estimate increasing, decreasing, or staying the same over time?
2. Is your county's trend better or worse than the state trend, or following a similar trend?
3. Is your county's trend better or worse than the national trend, or following a similar trend?

How can we measure change from year to year when the Rankings also change?

Ranks are great for garnering attention, simplifying a lot of complex data, and making comparisons between one community and another at a point in time--but they shouldn't be used alone to measure a community's progress. Rather, look at them as one tool among many. Because ranks are relative, they aren't as helpful in isolation – your county's rank depends not only on what is happening in your county, but also on what happens in all the other counties in your state. In fact, if every county in a state improved its health, their ranks would all stay the same. One way of examining how much progress your community has made on its journey to better health is to look at the various individual measures in the *County Health Rankings*.

Can we look at data by areas smaller than counties? For example, could we break it down by zip code?

The *County Health Rankings* currently do not provide data at the sub-county level. However, we encourage communities to consider the *Rankings* as a starting place for understanding their health and look for opportunities to supplement *Rankings* measures with local data. Our website, www.countyhealthrankings.org, has additional resources under the Rankings tab, in Using the *Rankings* Data, that can help communities interested in using finer grain data to enhance their community health snapshot.

Could you comment on how you arrived at the actual weights?

There is no one "correct" formula or "true" set of weights that perfectly represents the health of a community. Indeed, even a very good system by today's standards might not perform well over long periods of time or under all possible circumstances. *County Health Rankings* staff use information from a wide variety of sources--scientific research, available data, expert opinion, statistical analysis--to arrive at a set of easy to understand weights that reasonably reflect the different components and determinants of health. Of course, they are not perfect, but we believe they are reasonable estimates supported by the best available evidence balanced with the availability of health data and interpretability.

Which factors have the biggest impact?

Our estimate of the potential impact each factor has on health is reflected in the weights. The overall Health Factors summary score is a weighted composite of four components: Health behaviors (30%), Clinical care (20%), Social and economic factors (40%), and Physical environment (10%).

How sensitive are the Rankings to changes in the factors i.e. how "big" does a program have to be to affect the Rankings?

The *Rankings* are relatively insensitive to changes in any one of the Health Factors. We know that it takes changes across a community, incorporating all the multiple factors of health to see lasting change in the health of a community. That is why one program or policy is unlikely to cause marked changes in the *Rankings.*