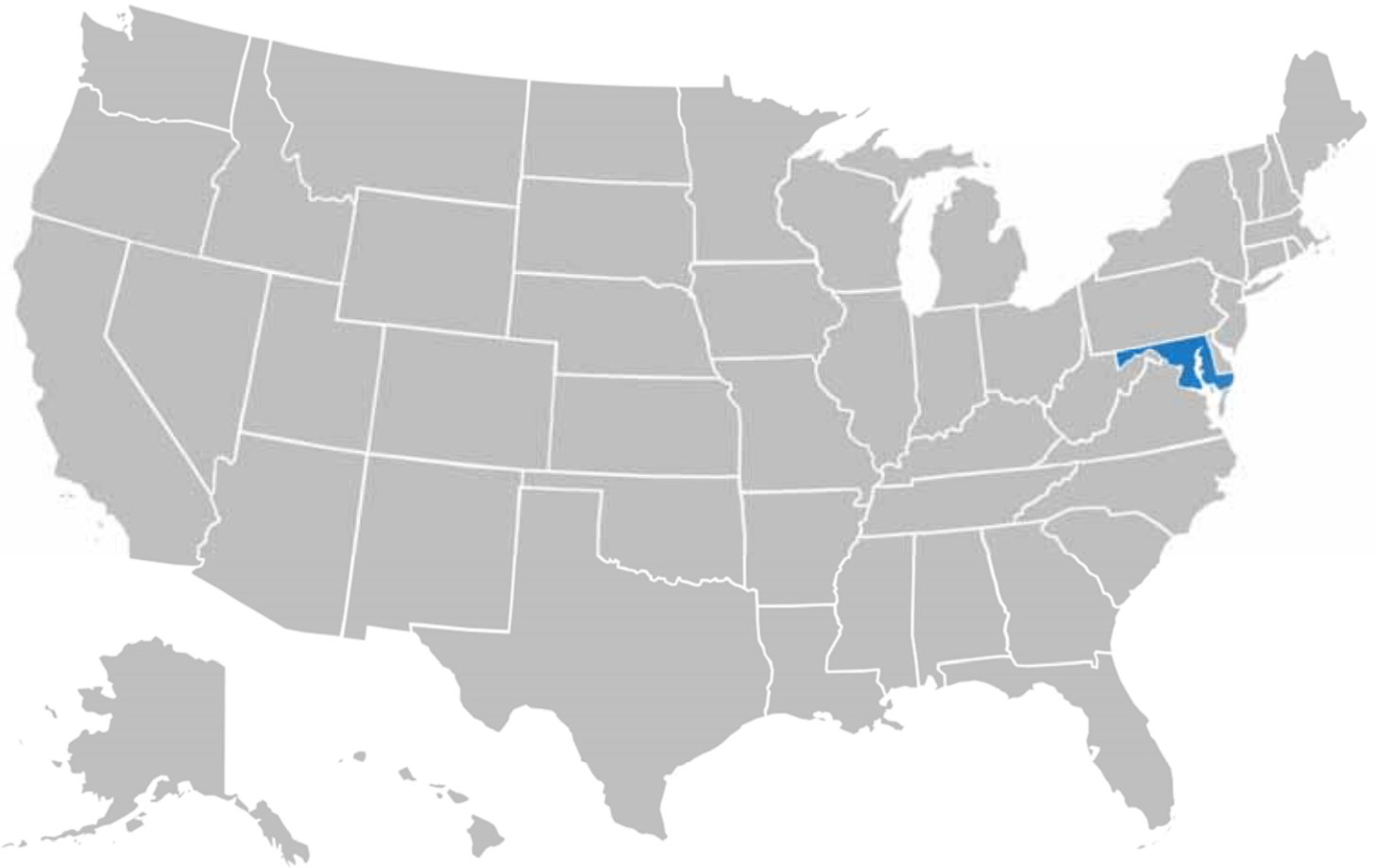


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Maryland



2019 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

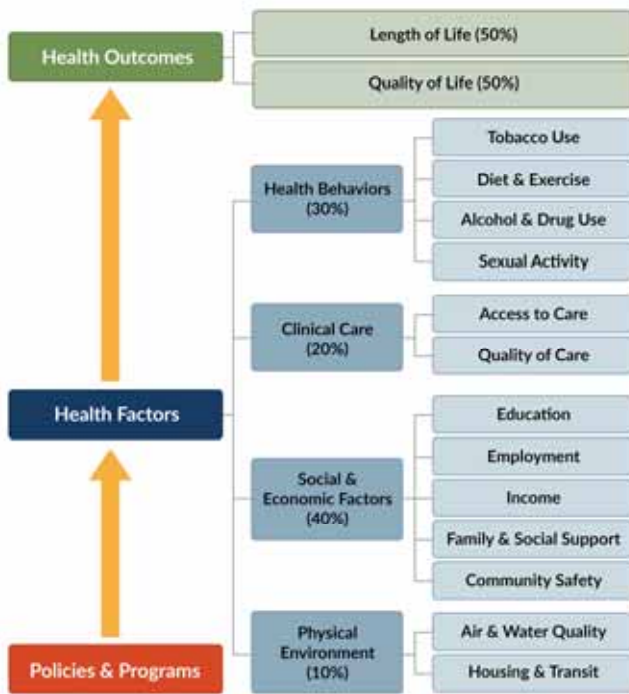


The County Health Rankings & Roadmaps (CHR&R) brings actionable data, evidence, guidance, and stories to communities to make it easier for people to be healthy in their neighborhoods, schools, and workplaces. Ranking the health of nearly every county in the nation (based on the model below), CHR&R illustrates 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.

What are the County Health Rankings?

Published online at countyhealthrankings.org, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings are unique in their ability to measure the current overall health of each county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births.

Communities use the Rankings to garner support for local health improvement initiatives among government agencies, health care providers, community organizations, business leaders, policymakers, and the public.



Moving with Data to Action

The Take Action to Improve Health section of our website, countyhealthrankings.org, helps communities join together to look at the many factors influencing health, select strategies that work, and make changes that will have a lasting impact. Take Action to Improve Health is a hub of information to help any community member or leader who wants to improve their community’s health and equity. You will find:

- What Works for Health, a searchable menu of evidence-informed policies and programs that can make a difference locally;
- The Action Center, your home for step-by-step guidance and tools to help you move with data to action;
- Action Learning Guides, self-directed learning on specific topics with a blend of guidance, tools, and hands-on practice and reflection activities;
- The Partner Center, information to help you identify the right partners and explore tips to engage them;
- Peer Learning, a virtual, interactive place to learn with and from others about what works in communities; and
- Action Learning Coaches, located across the nation, who are available to provide real-time guidance to local communities interested in learning how to accelerate their efforts to improve health and advance equity.

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.



Opportunities for Health Vary by Place and Race

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, in counties everywhere, 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.

Differences in Opportunity Have Been Created, and Can Be Undone

Differences in opportunity do not arise 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 discriminatory policing and prison sentencing. The collective effect is that a fair and just opportunity to live a long and healthy life does not exist for everyone. Now is the time to change how things are done.

Measure What Matters

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health and in the conditions and resources needed for optimal health. This report provides data on differences in health and opportunities in Maryland that can help identify where action is needed to achieve greater equity and offers information on how to move with data to action.

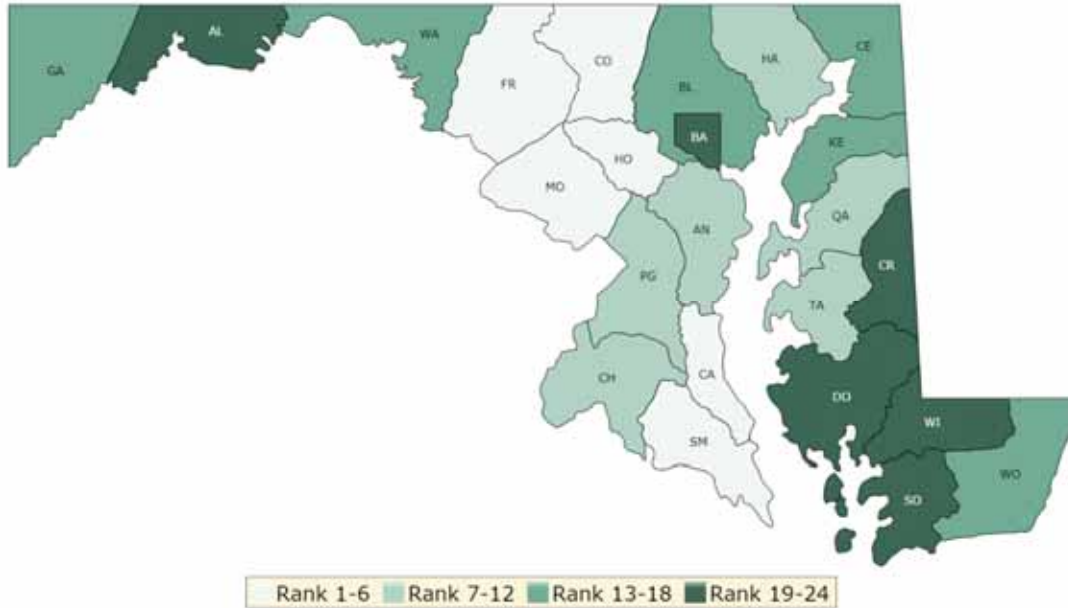
Specifically, this report will help illuminate:

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

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 (percent 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 Maryland’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 10 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 Maryland, 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 Maryland, and among racial/ethnic groups.

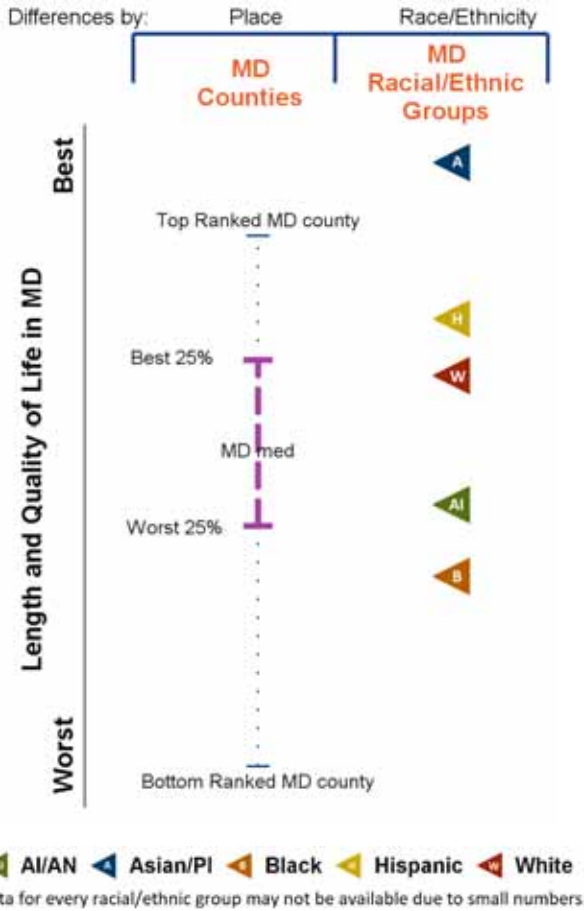
Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in Maryland

| | Healthiest MD County | Least Healthy MD County | AI/AN | Asian/PI | Black | Hispanic | White |
|---|----------------------|-------------------------|-------|----------|-------|----------|-------|
| Premature Death (years lost/100,000) | 4,100 | 13,200 | 4,400 | 2,800 | 9,600 | 3,700 | 6,700 |
| Poor or Fair Health (%) | 10% | 19% | 25% | 9% | 15% | 24% | 12% |
| Poor Physical Health Days (avg) | 2.4 | 3.7 | 5.5 | 1.6 | 3.0 | 3.6 | 3.1 |
| Poor Mental Health Days (avg) | 2.8 | 4.1 | 5.2 | 2.0 | 3.3 | 3.4 | 3.8 |
| Low Birthweight (%) | 7% | 12% | 9% | 8% | 12% | 7% | 7% |

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 Maryland



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 14.

Taken as a whole, measures of length and quality of life in Maryland indicate:

- American Indians/Alaskan Natives are most similar in health to those living in the middle 50% of counties.
- Asians/Pacific Islanders are healthier than those living in the top ranked county.
- 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 healthiest 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.)

AI/AN - American Indian/Alaskan Native/Native American
 Asian/PI - Asian/Pacific Islander

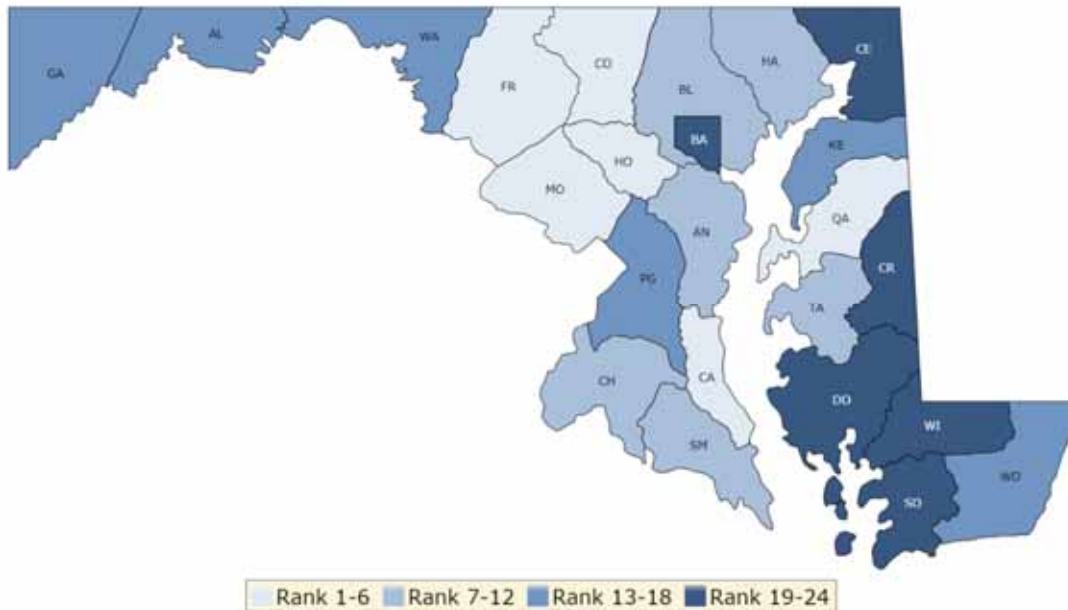
Across the US, values for measures of length and quality of life for Native American, Black, and Hispanic residents are regularly worse than for Whites and Asians. For example, even in the healthiest counties in the US, Black and American Indian premature death rates are about 1.4 times higher than White rates. Not only are these differences unjust and avoidable, they will also negatively impact our changing nation’s future prosperity.



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 Maryland’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 10.

What are the Factors That Drive Health and Health Equity and How Does Housing Play a Role?

Health is influenced by a range of factors. 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 interact with other important drivers of health and health equity. For example, housing that is unaffordable or unstable can either result from poverty or exacerbate it. When our homes are near high performing schools and good jobs, it’s easier to get a quality education and earn a living wage. When people live near grocery stores where fresh food is available or close to green spaces and parks, eating healthy and being active is easier. When things like lead, mold, smoke, and other toxins are inside our homes, they can make us sick. And when so much of a paycheck goes toward the rent or mortgage, it makes it hard to afford to go to the doctor, cover the utility bills, or maintain reliable transportation to work or school.

How Do Opportunities for Stable and Affordable Housing Vary in Maryland?

Housing is central to people’s opportunities for living long and well. Nationwide, housing costs far exceed affordability given local incomes in many communities. As a result, people have no choice but to spend too much on housing, leaving little left for other necessities. Here, we focus on stable and affordable housing as an essential element of healthy communities. We also explore the connection between housing and children in poverty to illuminate the fact that these issues are made even more difficult when family budgets are the tightest.

In 2017, in Maryland, more than 160,000 children lived in poverty

| | |
|--|--|
| <p>64% of Maryland’s children in poverty were living in a household that spends more than ½ of its income on housing costs</p>  | <p style="text-align: center;"><i>Leaving little left over for other essentials like...</i></p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Healthy Food</p> </div> <div style="text-align: center;">  <p>Transportation</p> </div> <div style="text-align: center;">  <p>Medical Care</p> </div> </div> |
|--|--|

What can work to create and preserve stable and affordable housing that can improve economic and social well-being and connect residents to opportunity?

A comprehensive, strategic approach that looks across a community and multiple sectors is needed to create and preserve stable, affordable housing in our communities. The way forward requires policies, programs, and systems changes that respond to the specific needs of each community, promote inclusive and connected neighborhoods, reduce displacement, and enable opportunity for better health for all people. This includes efforts to:

Make communities more inclusive and connected, such as:

- Inclusive zoning
- Civic engagement in public governance and in community development decisions
- Fair housing laws and enforcement
- Youth leadership programs
- Access to living wage jobs, quality health care, grocery stores, green spaces and parks, and public transportation systems

Facilitate access to resources needed to secure affordable housing, particularly for low- to middle-income families, such as:

- Housing choice vouchers for low- and very low-income households
- Housing trust funds

Address capital resources needed to create and preserve affordable housing, particularly for low- to middle-income families, such as:

- Acquisition, management, and financing of land for affordable housing, like land banks or land trusts
- Tax credits, block grants, and other government subsidies or revenues to advance affordable housing development
- Zoning changes that reduce the cost of housing production

For more information about evidence-informed strategies that can address priorities in your community, visit What Works for Health at countyhealthrankings.org/whatworks

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

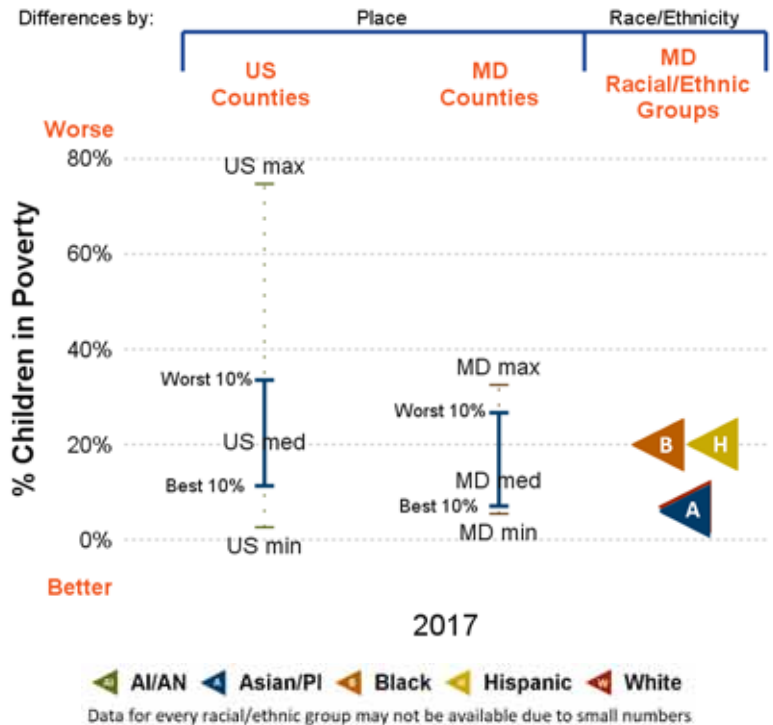
Consider these questions as you look at the data graphics throughout this report:

- 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.

- In Maryland, 12% of children are living in poverty.
- Children in poverty among Maryland counties range from 6% to 33%.
- Child poverty rates among racial/ethnic groups in Maryland range from 6% to 20%.

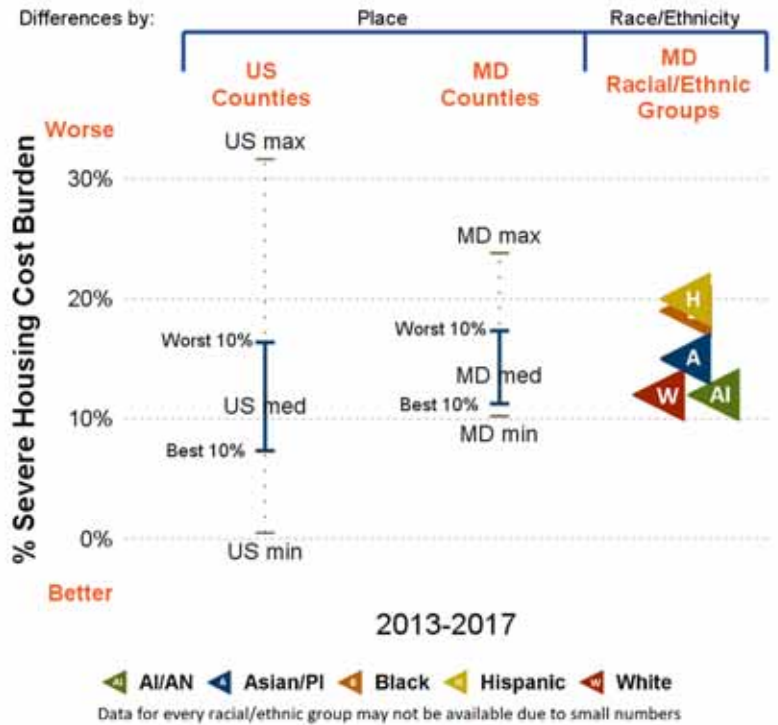


US and state values and the state minimum and maximum can be found in the table on page 12
 American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

SEVERE HOUSING COST BURDEN

There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs.

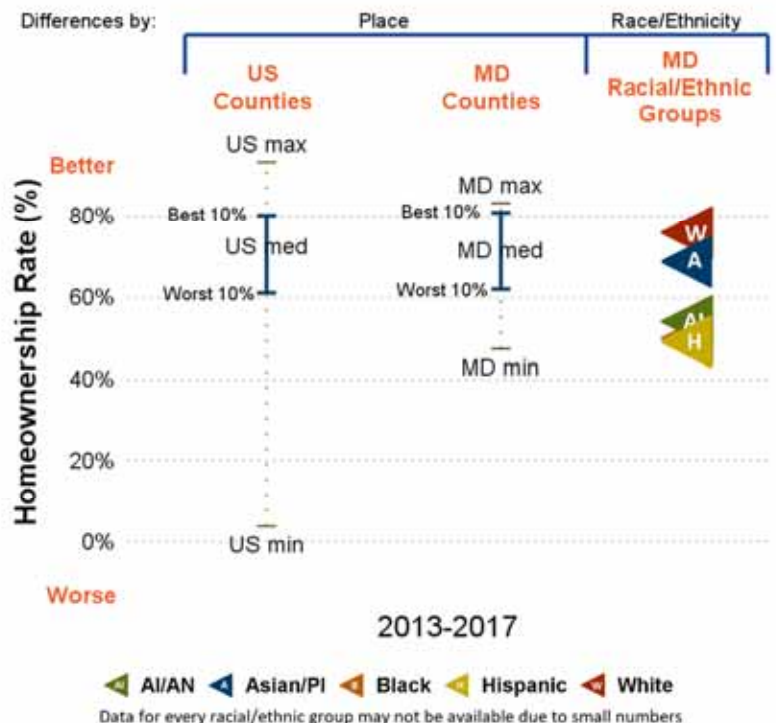
- In Maryland, 15% of households spend more than half of their income on housing costs.
- Across Maryland counties, severe housing cost burden ranges from 10% to 24% of households.
- Severe housing cost burden ranges from 12% to 20% among households headed by different racial/ethnic groups in Maryland.



HOMEOWNERSHIP

Homeownership has historically been a springboard for families to enter the middle class. Owning a home over time can help build savings for education or for other opportunities important to health and future family wealth. High levels of homeownership are associated with more stable housing and more tightly knit communities.

- In Maryland, 67% of households own their home.
- Homeownership rates among Maryland counties range from 47% to 83% of households.
- Homeownership rates among racial/ethnic groups in Maryland range from 49% to 76%.



2019 County Health Rankings for the 24 Ranked Counties in Maryland

| County | Health Outcomes | Health Factors |
|----------------|-----------------|----------------|
| Allegany | 20 | 18 |
| Anne Arundel | 8 | 8 |
| Baltimore | 13 | 10 |
| Baltimore City | 24 | 23 |
| Calvert | 6 | 5 |
| Caroline | 21 | 22 |
| Carroll | 4 | 3 |
| Cecil | 18 | 19 |

| County | Health Outcomes | Health Factors |
|------------|-----------------|----------------|
| Charles | 12 | 12 |
| Dorchester | 22 | 21 |
| Frederick | 3 | 4 |
| Garrett | 15 | 13 |
| Harford | 10 | 7 |
| Howard | 2 | 1 |
| Kent | 14 | 14 |
| Montgomery | 1 | 2 |

| County | Health Outcomes | Health Factors |
|-----------------|-----------------|----------------|
| Prince George's | 11 | 16 |
| Queen Anne's | 7 | 6 |
| Somerset | 23 | 24 |
| St. Mary's | 5 | 11 |
| Talbot | 9 | 9 |
| Washington | 17 | 15 |
| Wicomico | 19 | 20 |
| Worcester | 16 | 17 |



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!

2019 County Health Rankings for Maryland: Measures and National/State Results

| Measure | Description | US | MD | MD Minimum | MD Maximum |
|--------------------------------------|--|---------|---------|---------------|---------------|
| HEALTH OUTCOMES | | | | | |
| Premature death | Years of potential life lost before age 75 per 100,000 population | 6900 | 7,100 | 4,100 | 13,200 |
| Poor or fair health | % of adults reporting fair or poor health | 16% | 14% | 9% | 22% |
| Poor physical health days | Average # of physically unhealthy days reported in past 30 days | 3.7 | 3.1 | 2.4 | 4.5 |
| Poor mental health days | Average # of mentally unhealthy days reported in past 30 days | 3.8 | 3.5 | 2.8 | 4.6 |
| Low birthweight | % of live births with low birthweight (< 2500 grams) | 8% | 9% | 6% | 12% |
| HEALTH FACTORS | | | | | |
| HEALTH BEHAVIORS | | | | | |
| Adult smoking | % of adults who are current smokers | 17% | 14% | 7% | 21% |
| Adult obesity | % of adults that report a BMI ≥ 30 | 29% | 30% | 21% | 43% |
| Food environment index | Index of factors that contribute to a healthy food environment, (0-10) | 7.7 | 9.1 | 6.1 | 9.5 |
| Physical inactivity | % of adults aged 20 and over reporting no leisure-time physical activity | 22% | 21% | 15% | 31% |
| Access to exercise opportunities | % of population with adequate access to locations for physical activity | 84% | 92% | 35% | 100% |
| Excessive drinking | % of adults reporting binge or heavy drinking | 18% | 17% | 14% | 20% |
| Alcohol-impaired driving deaths | % of driving deaths with alcohol involvement | 29% | 30% | 19% | 56% |
| Sexually transmitted infections | # of newly diagnosed chlamydia cases per 100,000 population | 497.3 | 510.4 | 132.4 | 1,189.0 |
| Teen births | # of births per 1,000 female population ages 15-19 | 25 | 19 | 7 | 40 |
| CLINICAL CARE | | | | | |
| Uninsured | % of population under age 65 without health insurance | 10% | 7% | 4% | 11% |
| Primary care physicians | Ratio of population to primary care physicians | 1,330:1 | 1,140:1 | 2,880:1 | 510:1 |
| Dentists | Ratio of population to dentists | 1,460:1 | 1,300:1 | 2,770:1 | 660:1 |
| Mental health providers | Ratio of population to mental health providers | 440:1 | 430:1 | 2,770:1 | 230:1 |
| Preventable hospital stays | # of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees | 4,520 | 4,695 | 2,980 | 6,608 |
| Mammography screening | % of female Medicare enrollees ages 65-74 that receive mammography screening | 41% | 41% | 36% | 50% |
| Flu vaccinations | % of Medicare enrollees who receive an influenza vaccination | 45% | 48% | 37% | 55% |
| SOCIAL AND ECONOMIC FACTORS | | | | | |
| High school graduation | % of ninth-grade cohort that graduates in four years | 85% | 88% | 71% | 98% |
| Some college | % of adults ages 25-44 with some post-secondary education | 65% | 69% | 41% | 85% |
| Unemployment | % of population aged 16 and older unemployed but seeking work | 4.4% | 4.1% | 3.1% | 8.5% |
| Children in poverty | % of children under age 18 in poverty | 18% | 12% | 6% | 33% |
| Income inequality | Ratio of household income at the 80th percentile to income at the 20th percentile | 4.9 | 4.5 | 3.4 | 6.3 |
| Children in single-parent households | % of children that live in a household headed by a single parent | 33% | 34% | 20% | 63% |
| Social associations | # of membership associations per 10,000 population | 9.3 | 9.0 | 6.1 | 17.9 |
| Violent crime | # of reported violent crime offenses per 100,000 population | 386 | 459 | 150 | 1,566 |
| Injury deaths | # of deaths due to injury per 100,000 population | 67 | 70 | 36 | 142 |
| PHYSICAL ENVIRONMENT | | | | | |
| Air pollution – particulate matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) | 8.6 | 9.6 | 8.7 | 11.0 |
| Drinking water violations | Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation. | N/A | N/A | No | Yes |
| Severe housing problems | % of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities | 18% | 17% | 12% | 25% |
| Driving alone to work | % of workforce that drives alone to work | 76% | 74% | 60% | 86% |
| Long commute – driving alone | Among workers who commute in their car alone, % commuting > 30 minutes | 35% | 49% | 19% | 65% |

2019 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 | 2015-2017 |
| 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 | 2011-2017 |
| HEALTH FACTORS | | | |
| HEALTH BEHAVIORS | | | |
| Tobacco Use | Adult smoking | Behavioral Risk Factor Surveillance System | 2016 |
| Diet and Exercise | Adult obesity | CDC Diabetes Interactive Atlas | 2015 |
| | Food environment index | USDA Food Environment Atlas, Map the Meal Gap | 2015 & 2016 |
| | Physical inactivity | CDC Diabetes Interactive Atlas | 2015 |
| | Access to exercise opportunities | Business Analyst, Delorme map data, ESRI, & U.S. Census Files | 2010 & 2018 |
| Alcohol and Drug Use | Excessive drinking | Behavioral Risk Factor Surveillance System | 2016 |
| | Alcohol-impaired driving deaths | Fatality Analysis Reporting System | 2013-2017 |
| Sexual Activity | Sexually transmitted infections | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB | 2016 |
| | Teen births | National Center for Health Statistics – Natality files | 2011-2017 |
| CLINICAL CARE | | | |
| Access to Care | Uninsured | Small Area Health Insurance Estimates | 2016 |
| | Primary care physicians | Area Health Resource File/American Medical Association | 2016 |
| | Dentists | Area Health Resource File/National Provider Identification file | 2017 |
| | Mental health providers | CMS, National Provider Identification file | 2018 |
| Quality of Care | Preventable hospital stays | Mapping Medicare Disparities Tool | 2016 |
| | Mammography screening | Mapping Medicare Disparities Tool | 2016 |
| | Flu vaccinations | Mapping Medicare Disparities Tool | 2016 |
| SOCIAL AND ECONOMIC FACTORS | | | |
| Education | High school graduation | State-specific sources & ED Facts | Varies |
| | Some college | American Community Survey | 2013-2017 |
| Employment | Unemployment | Bureau of Labor Statistics | 2017 |
| Income | Children in poverty | Small Area Income and Poverty Estimates | 2017 |
| | Income inequality | American Community Survey | 2013-2017 |
| Family and Social Support | Children in single-parent households | American Community Survey | 2013-2017 |
| | Social associations | County Business Patterns | 2016 |
| Community Safety | Violent crime | Uniform Crime Reporting – FBI | 2014 & 2016 |
| | Injury deaths | CDC WONDER mortality data | 2013-2017 |
| PHYSICAL ENVIRONMENT | | | |
| Air and Water Quality | Air pollution – particulate matter* | Environmental Public Health Tracking Network | 2014 |
| | Drinking water violations | Safe Drinking Water Information System | 2017 |
| Housing and Transit | Severe housing problems | Comprehensive Housing Affordability Strategy (CHAS) data | 2011-2015 |
| | Driving alone to work | American Community Survey | 2013-2017 |
| | Long commute – driving alone | American Community Survey | 2013-2017 |

*Not available for AK and HI.

2019 County Health Rankings: Additional Measure Sources and Years of Data

| | Measure | Source | Years of Data |
|--------------------------------------|---|---|---------------|
| HEALTH OUTCOMES | | | |
| Length of Life | Life expectancy | National Center for Health Statistics - Mortality Files | 2015-2017 |
| | Premature age-adjusted mortality | CDC WONDER mortality data | 2015-2017 |
| | Child mortality | CDC WONDER mortality data | 2014-2017 |
| | Infant mortality | CDC WONDER mortality data | 2011-2017 |
| Quality of Life | Frequent physical distress | Behavioral Risk Factor Surveillance System | 2016 |
| | Frequent mental distress | Behavioral Risk Factor Surveillance System | 2016 |
| | Diabetes prevalence | CDC Diabetes Interactive Atlas | 2015 |
| | HIV prevalence | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | 2015 |
| HEALTH FACTORS | | | |
| HEALTH BEHAVIORS | | | |
| Diet and Exercise | Food insecurity | Map the Meal Gap | 2016 |
| | Limited access to healthy foods | USDA Food Environment Atlas | 2015 |
| Alcohol and Drug Use | Drug overdose deaths | CDC WONDER mortality data | 2015-2017 |
| | Motor vehicle crash deaths | CDC WONDER mortality data | 2011-2017 |
| Other Health Behaviors | Insufficient sleep | Behavioral Risk Factor Surveillance System | 2016 |
| CLINICAL CARE | | | |
| Access to Care | Uninsured adults | Small Area Health Insurance Estimates | 2016 |
| | Uninsured children | Small Area Health Insurance Estimates | 2016 |
| | Other primary care providers | CMS, National Provider Identification File | 2018 |
| SOCIAL & ECONOMIC FACTORS | | | |
| Education | Disconnected youth | American Community Survey | 2013-2017 |
| Income | Median household income | Small Area Income and Poverty Estimates | 2017 |
| | Children eligible for free or reduced price lunch | National Center for Education Statistics | 2016-2017 |
| Family and Social Support | Residential segregation - black/white | American Community Survey | 2013-2017 |
| | Residential segregation - non-white/white | American Community Survey | 2013-2017 |
| Community Safety | Homicides | CDC WONDER mortality data | 2011-2017 |
| | Firearm fatalities | CDC WONDER mortality data | 2013-2017 |
| PHYSICAL ENVIRONMENT | | | |
| Housing and Transit | Homeownership | American Community Survey | 2013-2017 |
| | Severe housing cost burden | American Community Survey | 2013-2017 |
| DEMOGRAPHICS | | | |
| All | Population | Census Population Estimates | 2017 |
| | % below 18 years of age | Census Population Estimates | 2017 |
| | % 65 and older | Census Population Estimates | 2017 |
| | % Non-Hispanic African American | Census Population Estimates | 2017 |
| | % American Indian and Alaskan Native | Census Population Estimates | 2017 |
| | % Asian | Census Population Estimates | 2017 |
| | % Native Hawaiian/Other Pacific Islander | Census Population Estimates | 2017 |
| | % Hispanic | Census Population Estimates | 2017 |
| | % Non-Hispanic white | Census Population Estimates | 2017 |
| | % not proficient in English | American Community Survey | 2013-2017 |
| | % Females | Census Population Estimates | 2017 |
| | % Rural | Census Population Estimates | 2010 |

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 14. 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.

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County Health Rankings & Roadmaps

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