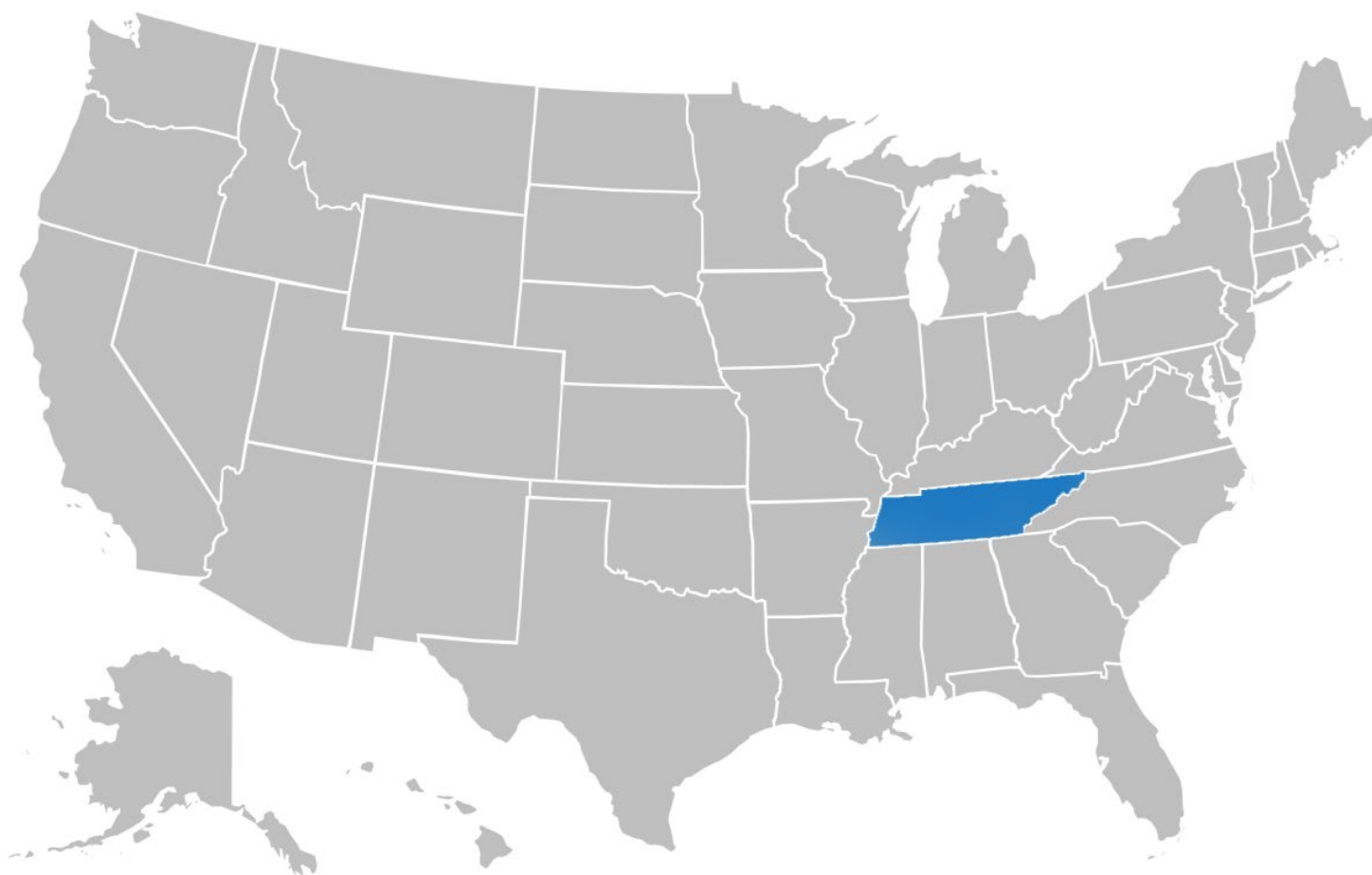


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

2022 State Report Tennessee



University of Wisconsin
Population Health Institute
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Support
provided by



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Foundation

2022 County Health Rankings for the 95 Ranked Counties in Tennessee

| County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors | County | Health Outcomes | Health Factors |
|------------|-----------------|----------------|-----------|-----------------|----------------|------------|-----------------|----------------|------------|-----------------|----------------|
| Anderson | 38 | 14 | Fentress | 70 | 66 | Lauderdale | 90 | 94 | Roane | 43 | 19 |
| Bedford | 42 | 62 | Franklin | 23 | 29 | Lawrence | 50 | 46 | Robertson | 16 | 15 |
| Benton | 86 | 80 | Gibson | 57 | 35 | Lewis | 73 | 74 | Rutherford | 3 | 6 |
| Bledsoe | 21 | 90 | Giles | 52 | 49 | Lincoln | 48 | 36 | Scott | 84 | 82 |
| Blount | 8 | 7 | Grainger | 76 | 52 | Loudon | 7 | 8 | Sequatchie | 41 | 69 |
| Bradley | 15 | 22 | Greene | 51 | 41 | Macon | 58 | 83 | Sevier | 26 | 58 |
| Campbell | 91 | 78 | Grundy | 92 | 87 | Madison | 45 | 28 | Shelby | 74 | 75 |
| Cannon | 72 | 45 | Hamblen | 46 | 54 | Marion | 56 | 53 | Smith | 33 | 33 |
| Carroll | 47 | 31 | Hamilton | 14 | 10 | Marshall | 25 | 40 | Stewart | 22 | 32 |
| Carter | 65 | 43 | Hancock | 94 | 93 | Maury | 6 | 11 | Sullivan | 30 | 12 |
| Ceatham | 31 | 13 | Hardeman | 89 | 88 | McMinn | 59 | 44 | Sumner | 5 | 5 |
| Chester | 12 | 23 | Hardin | 82 | 56 | McNairy | 64 | 64 | Tipton | 27 | 27 |
| Claiborne | 79 | 68 | Hawkins | 60 | 57 | Meigs | 88 | 71 | Trousdale | 19 | 48 |
| Clay | 87 | 91 | Haywood | 95 | 86 | Monroe | 68 | 60 | Unicoi | 77 | 42 |
| Cocke | 93 | 89 | Henderson | 55 | 72 | Montgomery | 13 | 18 | Union | 80 | 79 |
| Coffee | 35 | 26 | Henry | 71 | 50 | Moore | 4 | 9 | Van Buren | 83 | 85 |
| Crockett | 62 | 37 | Hickman | 66 | 61 | Morgan | 78 | 76 | Warren | 49 | 81 |
| Cumberland | 32 | 24 | Houston | 75 | 63 | Obion | 53 | 51 | Washington | 18 | 4 |
| Davidson | 10 | 16 | Humphreys | 39 | 34 | Overton | 29 | 47 | Wayne | 36 | 77 |
| Decatur | 44 | 55 | Jackson | 63 | 84 | Perry | 61 | 92 | Weakley | 17 | 21 |
| DeKalb | 67 | 73 | Jefferson | 28 | 25 | Pickett | 37 | 59 | White | 34 | 38 |
| Dickson | 24 | 20 | Johnson | 69 | 70 | Polk | 54 | 39 | Williamson | 1 | 1 |
| Dyer | 81 | 65 | Knox | 11 | 2 | Putnam | 9 | 30 | Wilson | 2 | 3 |
| Fayette | 20 | 17 | Lake | 85 | 95 | Rhea | 40 | 67 | | | |

For more information on how these ranks are calculated, view the technical notes at the end of this report and visit www.countyhealthrankings.org

County Health Rankings & Roadmaps (CHR&R) brings actionable data, evidence, guidance, and stories to diverse leaders and residents so people and communities can be healthier. The University of Wisconsin Population Health Institute created CHR&R for communities across the nation, with funding from the Robert Wood Johnson Foundation.

What are the County Health Rankings?

The Rankings help us understand what influences how long and how well we live. They provide measures of the *current* overall health (health outcomes) of each county in all 50 states and the District of Columbia. Rankings data include a variety of measures, such as high school graduation rates, access to nutritious foods, and the percent of children living in poverty, all of which impact the *future* health of communities (health factors).



We believe in a future where everyone has opportunities to be healthy and to thrive. Many factors impact how long and how well we live. Our data show how these factors shape community conditions, while highlighting the stark differences in health that stem from injustices and barriers to opportunity. Use our resources to take action toward better health for all.

Communities use the Rankings to build support for local health improvement initiatives by engaging many sectors including public health, health care, business, policymakers, and local residents.

The County Health Rankings Model

The County Health Rankings Model illustrates a broad vision for health. The model shows that policies and programs at the local, state, and federal levels play an important role in shaping health factors that in turn, influence a community's health outcomes.

Health factors represent things that, if modified, can improve length and quality of life. They are predictors of how healthy our communities can be in the future. The four health factor areas in the model include Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

Health outcomes represent how healthy a county is right now. They reflect the physical and mental well-being of residents through measures representing the length and quality of life typically experienced in the community.



Growing Healthy Places Means Ensuring Opportunities for All

Communities thrive when all people can be healthy in their neighborhoods, schools, and workplaces. CHR&R brings actionable data and strategies to communities working to ensure that healthy places are available to all. Pages 5 and 6 of this report highlight how health outcomes and health factors differ by place within Tennessee. On page 7, we outline how economic security – or the ability of individuals, households, and communities to meet basic needs with dignity – is important to health. We call attention to childcare cost burden as a barrier to economic security and health.



Growing Community Power to Improve Health Equity

The [Take Action to Improve Health](#) section of the CHR&R website helps communities find tools and guidance to take action, select evidence-informed strategies, and make lasting changes. Take Action to Improve Health is a hub for information to help improve a community's health and foster health equity. Find resources including:

- [What Works for Health](#), a searchable menu of evidence-informed strategies.
- [Action Learning Guides](#), self-directed learning modules that combine guidance, tools, and reflection activities.

Using Data to Improve Health Equity

Data show a persistent pattern across the country in barriers to opportunity for people with lower incomes and for people of color. Differences in the opportunities available to different groups of people are related to unfair policies and practices.

Our progress toward health equity will be measured by how health disparities change over time. Visit www.countyhealthrankings.org to learn more about:

1. Health outcome and factor measures for your state and county.
2. Measures with data available by race and ethnicity to illuminate differences in opportunities for health.
3. Additional data resources for Tennessee that provide information about health and opportunity by age group, gender, and zip code.

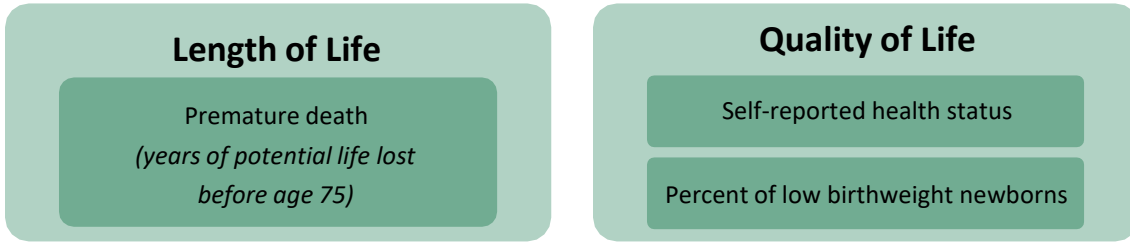
What Has Been Done Can Be Undone

Achieving health equity means eliminating unjust and avoidable differences in access and opportunity. What can communities do to tackle unfair differences in how long and how well people live? Check out new strategies at [What Works for Health](#) that can address past harms and create conditions for thriving communities for everyone.

Many communities are mobilizing to harness the collective power of residents, organizations, and policymakers. They are working together to address past and present policies that cause harm and are ensuring the growth of healthy places for all. To learn about these efforts, visit countyhealthrankings.org.

What are Health Outcomes?

We measure length and quality of life to understand the health outcomes among counties in Tennessee.



How Do Counties Rank for Health Outcomes?

The green map shows Tennessee’s **health outcome rankings** by county. The map is divided into four quartiles with less color intensity indicating better health outcomes. Specific county ranks can be found in the table on page 2.

Detailed information on the measures and their associated weights is available toward the end of this report. Learn about how we calculate health outcome ranks at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health outcome rank, with a top-ranked county (rank = 1) having the best health outcome score. Ranks are good for sparking conversations, but they do not show differences in health within counties or describe the magnitude of difference in community health experienced between ranks. The chart next to the map shows the spread of health outcome scores (ranks) for each county (green circles) in Tennessee. This graphic shows the size of the gaps *between* ranked counties. The background colors correspond to the map legend.

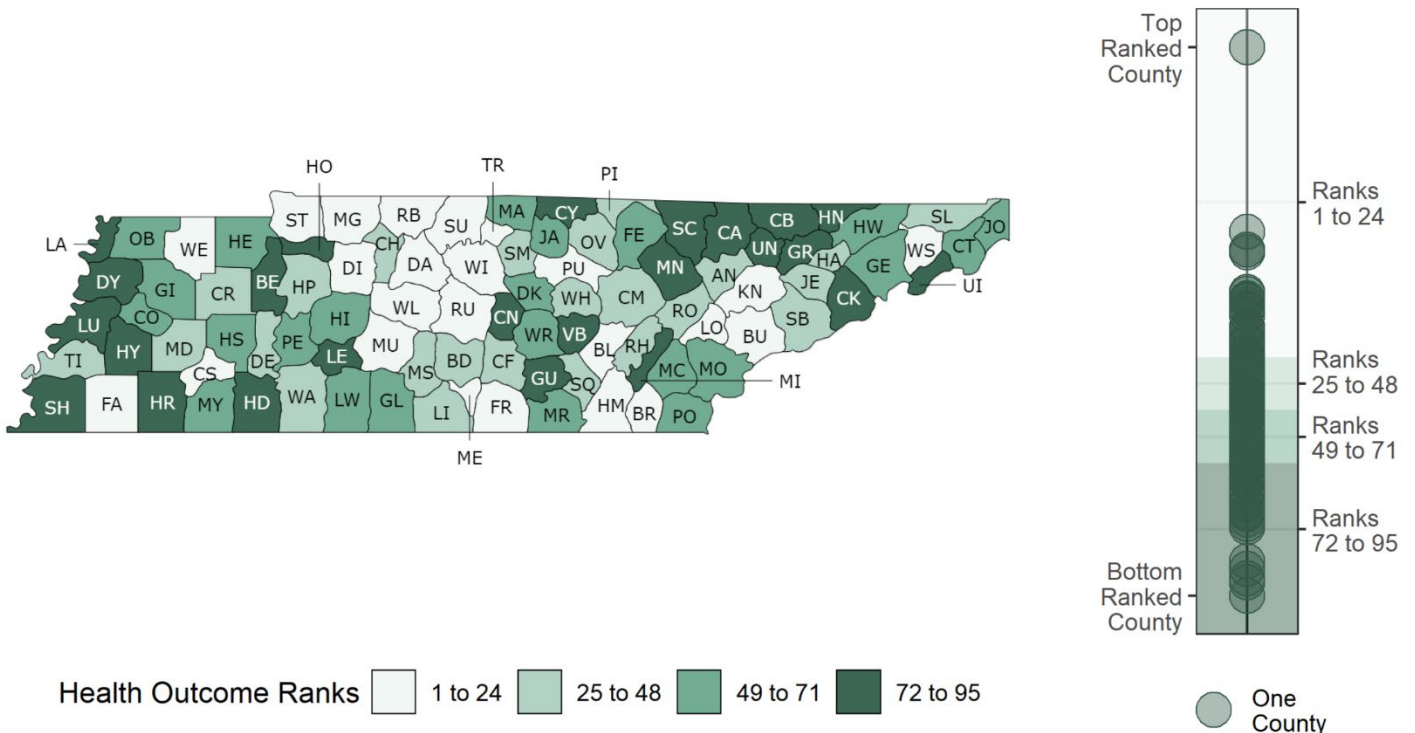
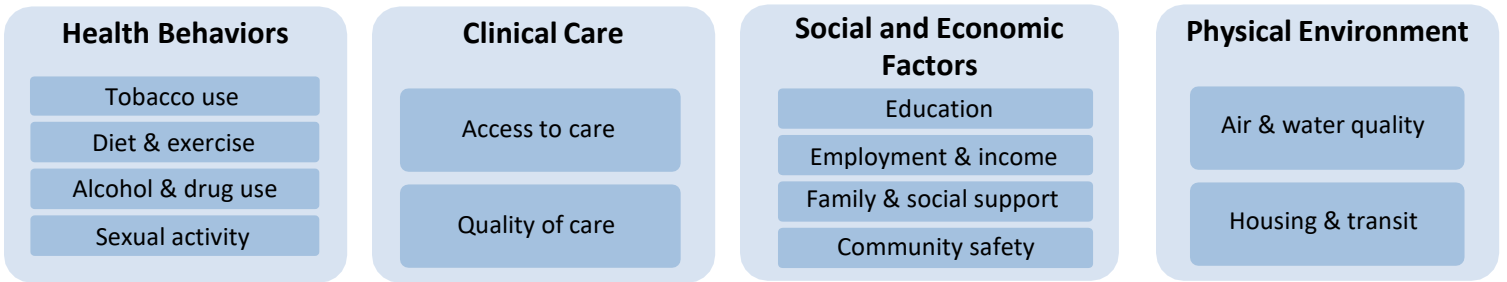


Figure 1. Health outcome ranks displayed using quartiles (map) and underlying health outcome scores (chart)

What are Health Factors?

Health factors represent community conditions that we can change to improve health and opportunity, such as access to quality education, living wage jobs, quality clinical care, nutritious foods, green spaces, and secure and affordable housing. We measure four health factor areas.



How Do Counties Rank for Health Factors?

The blue map shows Tennessee’s **health factor rankings** by county. The map is divided into four quartiles with less color intensity indicating better health factors. Specific county ranks can be found in the table on page 2.

Detailed information on the measures and their associated weights is available toward the end of this report. You can also learn about how we calculate health factor ranks at www.countyhealthrankings.org.

What Do Differences Between Ranks Mean?

Counties are ordered by the health factor rank, with a top-ranked county (rank = 1) having the best health factor score. The chart next to the map shows the spread of health factor scores (ranks) for each ranked county (blue circles) in Tennessee. This graphic shows the size of the gaps *between* ranked counties. The background colors correspond to the map legend.

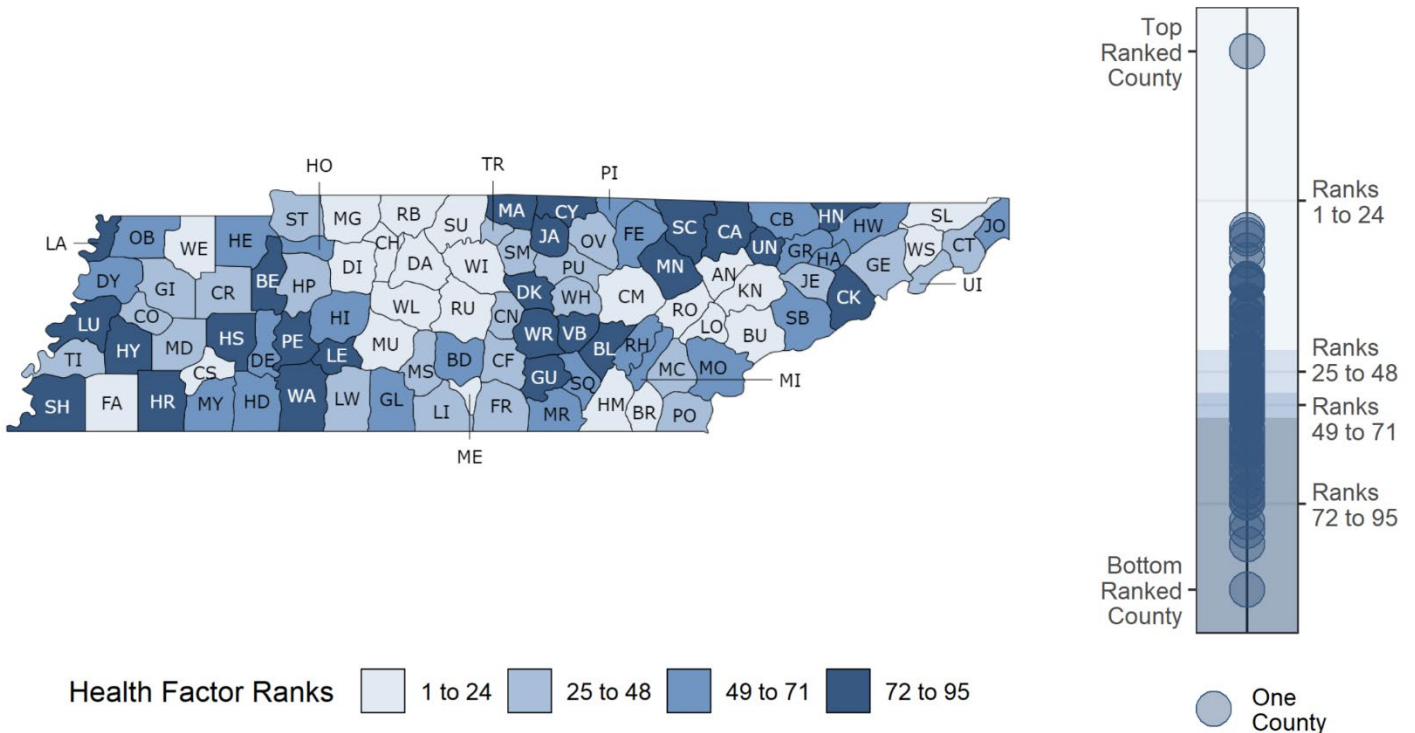


Figure 2. Health factor ranks displayed using quartiles (map) and underlying health factor scores (chart)

Economic Security is Key to Thriving Communities

Economic security enables families to cover basic needs such as housing, education, childcare, food, and medical care. Each of these needs has demonstrated ties to health. However, economic security is not equally accessible to all people. When a single household expense consumes the majority of a paycheck, it becomes difficult to meet competing needs and can force households into tough decisions like choosing between quality childcare, paying rent, and purchasing nutritious food. Individuals, households, and communities deserve the opportunity to meet basic needs with dignity. Advancing a just recovery from the COVID-19 pandemic, and the layered impacts of racism and economic exclusion requires intentional action to ensure all people and places have what they need to thrive. Check out policies and programs that can be implemented in your community at [What Works for Health](#).

Childcare Cost Burden in Tennessee and the U.S.

Childcare cost burden measures the percentage of household income needed to pay for childcare. When childcare is affordable and accessible, it can support parents’ and guardians’ ability to participate in paid work and can provide lifelong benefits to children. The U.S. Department of Health and Human Services’ benchmark suggests childcare is no longer affordable if it exceeds 7% of a household’s income. This measure of childcare cost burden reflects the experience of a household with two children.

Childcare Cost Burden in Tennessee Counties

The childcare cost burden among counties in Tennessee ranges from 11% to 33%.

In Context

- Childcare cost burden varies by county level of urbanization ranging from 18% in Large suburban metro counties to 23% in Large urban metro counties.
- Median household income varies by race and ethnicity across Tennessee counties ranging between \$40,020 for Black households to \$81,886 for Asian households. These income disparities demonstrate how economic security is not equally accessible to all people living in Tennessee.

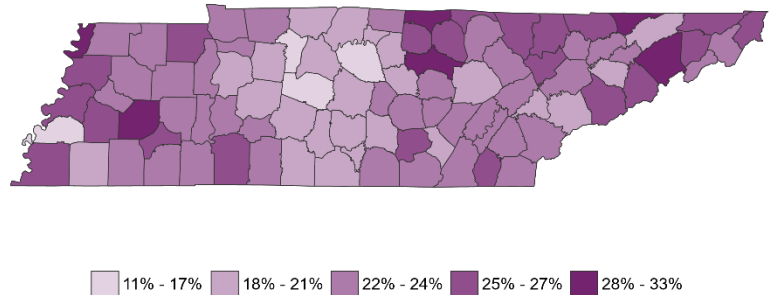


Figure 3. Childcare cost burden in Tennessee by county

Childcare Cost Burden Across the U.S.

The typical cost burden of childcare among counties in the U.S. is about 25% of household income – meaning a quarter of every dollar earned goes to paying for childcare. Families in every state experience a childcare cost higher than the 7% federal benchmark of affordability. The childcare cost burden in Tennessee is 22%.

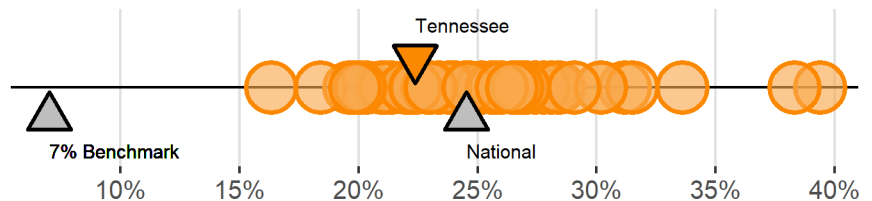


Figure 4. Childcare cost burden in the U.S. by state

Want to learn more? Visit our [State Reports page at www.countyhealthrankings.org](http://www.countyhealthrankings.org) to interact with the data.

2022 County Health Rankings: National and Tennessee State Values for Ranked Measures

| Measure | Description | US | TN | TN Minimum | TN Maximum |
|--------------------------------------|---|---------|---------|------------|------------|
| HEALTH OUTCOMES | | | | | |
| Premature death* | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 7,300 | 9,900 | 4,500 | 15,100 |
| Poor or fair health | Percentage of adults reporting fair or poor health (age-adjusted). | 17% | 20% | 14% | 32% |
| Poor physical health days | Average number of physically unhealthy days reported in past 30 days (age-adjusted). | 3.9 | 4.5 | 3.3 | 6.0 |
| Poor mental health days | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | 4.5 | 5.1 | 4.3 | 6.4 |
| Low birthweight* | Percentage of live births with low birthweight (< 2,500 grams). | 8% | 9% | 6% | 12% |
| HEALTH FACTORS | | | | | |
| HEALTH BEHAVIORS | | | | | |
| Adult smoking | Percentage of adults who are current smokers (age-adjusted). | 16% | 21% | 13% | 31% |
| Adult obesity | Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m ² (age-adjusted). | 32% | 37% | 29% | 46% |
| Food environment index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 7.8 | 6.2 | 5.0 | 9.1 |
| Physical inactivity | Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted). | 26% | 29% | 22% | 41% |
| Access to exercise opportunities | Percentage of population with adequate access to locations for physical activity. | 80% | 62% | 0% | 100% |
| Excessive drinking | Percentage of adults reporting binge or heavy drinking (age-adjusted). | 20% | 17% | 12% | 19% |
| Alcohol-impaired driving deaths | Percentage of driving deaths with alcohol involvement. | 27% | 23% | 6% | 67% |
| Sexually transmitted infections | Number of newly diagnosed chlamydia cases per 100,000 population. | 551.0 | 601.7 | 79.2 | 1,131.6 |
| Teen births* | Number of births per 1,000 female population ages 15-19. | 19 | 27 | 4 | 82 |
| CLINICAL CARE | | | | | |
| Uninsured | Percentage of population under age 65 without health insurance. | 11% | 12% | 6% | 18% |
| Primary care physicians | Ratio of population to primary care physicians. | 1,310:1 | 1,400:1 | 15,060:1 | 550:1 |
| Dentists | Ratio of population to dentists. | 1,400:1 | 1,790:1 | 18,790:1 | 1,210:1 |
| Mental health providers | Ratio of population to mental health providers. | 350:1 | 590:1 | 16,840:1 | 250:1 |
| Preventable hospital stays* | Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. | 3,767 | 4,331 | 2,483 | 10,115 |
| Mammography screening* | Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. | 43% | 43% | 27% | 56% |
| Flu vaccinations* | Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. | 48% | 50% | 19% | 59% |
| SOCIAL & ECONOMIC FACTORS | | | | | |
| High school completion | Percentage of adults ages 25 and over with a high school diploma or equivalent. | 89% | 88% | 74% | 95% |
| Some college | Percentage of adults ages 25-44 with some post-secondary education. | 67% | 62% | 29% | 85% |
| Unemployment | Percentage of population ages 16 and older unemployed but seeking work. | 8.1% | 7.5% | 4.8% | 10.2% |
| Children in poverty* | Percentage of people under age 18 in poverty. | 16% | 18% | 4% | 40% |
| Income inequality | Ratio of household income at the 80th percentile to income at the 20th percentile. | 4.9 | 4.7 | 3.4 | 8.5 |
| Children in single-parent households | Percentage of children that live in a household headed by a single parent. | 25% | 28% | 10% | 48% |
| Social associations | Number of membership associations per 10,000 population. | 9.2 | 11.1 | 0.0 | 20.2 |
| Violent crime | Number of reported violent crime offenses per 100,000 population. | 386 | 621 | 111 | 1,346 |
| Injury deaths* | Number of deaths due to injury per 100,000 population. | 76 | 100 | 56 | 150 |
| PHYSICAL ENVIRONMENT | | | | | |
| Air pollution - particulate matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). | 7.5 | 8.0 | 6.6 | 9.9 |
| 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 | N/A | N/A |
| Severe housing problems | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 17% | 14% | 5% | 19% |
| Driving alone to work* | Percentage of the workforce that drives alone to work. | 75% | 82% | 74% | 90% |
| Long commute - driving alone | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 37% | 36% | 14% | 66% |

*Indicates subgroup data by race and ethnicity is available; *Not available in all states

2022 County Health Rankings: Ranked Measure Sources and Years of Data

| | Measure | Weight | Source | Years of Data |
|--------------------------------------|--|--------|---|---------------|
| HEALTH OUTCOMES | | | | |
| Length of Life | Premature death* | 50% | National Center for Health Statistics - Mortality Files | 2018-2020 |
| Quality of Life | Poor or fair health [†] | 10% | Behavioral Risk Factor Surveillance System | 2019 |
| | Poor physical health days [†] | 10% | Behavioral Risk Factor Surveillance System | 2019 |
| | Poor mental health days [†] | 10% | Behavioral Risk Factor Surveillance System | 2019 |
| | Low birthweight* | 20% | National Center for Health Statistics - Natality files | 2014-2020 |
| HEALTH FACTORS | | | | |
| HEALTH BEHAVIORS | | | | |
| Tobacco Use | Adult smoking [†] | 10% | Behavioral Risk Factor Surveillance System | 2019 |
| Diet and Exercise | Adult obesity [†] | 5% | Behavioral Risk Factor Surveillance System | 2019 |
| | Food environment index | 2% | USDA Food Environment Atlas, Map the Meal Gap from Feeding America | 2019 |
| | Physical inactivity [†] | 2% | Behavioral Risk Factor Surveillance System | 2019 |
| | Access to exercise opportunities | 1% | Business Analyst, ESRI, YMCA & US Census Tigerline Files | 2010 & 2021 |
| Alcohol and Drug Use | Excessive drinking [†] | 2.5% | Behavioral Risk Factor Surveillance System | 2019 |
| | Alcohol-impaired driving deaths | 2.5% | Fatality Analysis Reporting System | 2016-2020 |
| Sexual Activity | Sexually transmitted infections | 2.5% | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | 2019 |
| | Teen births* | 2.5% | National Center for Health Statistics - Natality files | 2014-2020 |
| CLINICAL CARE | | | | |
| Access to Care | Uninsured | 5% | Small Area Health Insurance Estimates | 2019 |
| | Primary care physicians | 3% | Area Health Resource File/American Medical Association | 2019 |
| | Dentists | 1% | Area Health Resource File/National Provider Identification file | 2020 |
| | Mental health providers | 1% | CMS, National Provider Identification | 2021 |
| Quality of Care | Preventable hospital stays* | 5% | Mapping Medicare Disparities Tool | 2019 |
| | Mammography screening* | 2.5% | Mapping Medicare Disparities Tool | 2019 |
| | Flu vaccinations* | 2.5% | Mapping Medicare Disparities Tool | 2019 |
| SOCIAL & ECONOMIC FACTORS | | | | |
| Education | High school completion | 5% | American Community Survey, 5-year estimates | 2016-2020 |
| | Some college | 5% | American Community Survey, 5-year estimates | 2016-2020 |
| Employment | Unemployment | 10% | Bureau of Labor Statistics | 2020 |
| Income | Children in poverty* | 7.5% | Small Area Income and Poverty Estimates | 2020 |
| | Income inequality | 2.5% | American Community Survey, 5-year estimates | 2016-2020 |
| Family and Social Support | Children in single-parent households | 2.5% | American Community Survey, 5-year estimates | 2016-2020 |
| | Social associations | 2.5% | County Business Patterns | 2019 |
| Community Safety | Violent crime | 2.5% | Uniform Crime Reporting - FBI | 2014 & 2016 |
| | Injury deaths* | 2.5% | National Center for Health Statistics - Mortality Files | 2016-2020 |
| PHYSICAL ENVIRONMENT | | | | |
| Air and Water Quality | Air pollution - particulate matter | 2.5% | Environmental Public Health Tracking Network | 2018 |
| | Drinking water violations [‡] | 2.5% | Safe Drinking Water Information System | 2020 |
| Housing and Transit | Severe housing problems | 2% | Comprehensive Housing Affordability Strategy (CHAS) data | 2014-2018 |
| | Driving alone to work* | 2% | American Community Survey, 5-year estimates | 2016-2020 |
| | Long commute - driving alone | 1% | American Community Survey, 5-year estimates | 2016-2020 |

*Indicates subgroup data by race and ethnicity is available; *Not available in all states; [†]2018 data for New Jersey.

2022 County Health Rankings: Additional Measure Sources and Years of Data

| | Measure | Source | Years of Data |
|--------------------------------------|--|---|---------------|
| HEALTH OUTCOMES | | | |
| Length of Life | COVID-19 age-adjusted mortality | National Center for Health Statistics - Mortality Files | 2020 |
| | Life expectancy* | National Center for Health Statistics - Mortality Files | 2018-2020 |
| | Premature age-adjusted mortality* | National Center for Health Statistics - Mortality Files | 2018-2020 |
| | Child mortality* | National Center for Health Statistics - Mortality Files | 2017-2020 |
| | Infant mortality* | National Center for Health Statistics - Mortality Files | 2014-2020 |
| Quality of Life | Frequent physical distress [†] | Behavioral Risk Factor Surveillance System | 2019 |
| | Frequent mental distress [†] | Behavioral Risk Factor Surveillance System | 2019 |
| | Diabetes prevalence [‡] | Behavioral Risk Factor Surveillance System | 2019 |
| | HIV prevalence [‡] | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention | 2019 |
| HEALTH FACTORS | | | |
| HEALTH BEHAVIORS | | | |
| Diet and Exercise | Food insecurity | Map the Meal Gap | 2019 |
| | Limited access to healthy foods | USDA Food Environment Atlas | 2019 |
| Alcohol and Drug Use | Drug overdose deaths* | National Center for Health Statistics - Mortality Files | 2018-2020 |
| | Motor vehicle crash deaths* | National Center for Health Statistics - Mortality Files | 2014-2020 |
| Other Health Behaviors | Insufficient sleep | Behavioral Risk Factor Surveillance System | 2018 |
| CLINICAL CARE | | | |
| Access to Care | Uninsured adults | Small Area Health Insurance Estimates | 2019 |
| | Uninsured children | Small Area Health Insurance Estimates | 2019 |
| | Other primary care providers | CMS, National Provider Identification | 2021 |
| SOCIAL & ECONOMIC FACTORS | | | |
| Education | High school graduation [‡] | EDFacts | 2018-2019 |
| | Disconnected youth | American Community Survey, 5-year estimates | 2016-2020 |
| | Reading scores** | Stanford Education Data Archive | 2018 |
| | Math scores** | Stanford Education Data Archive | 2018 |
| | School segregation | National Center for Education Statistics | 2020-2021 |
| | School funding adequacy [‡] | School Finance Indicators Database | 2019 |
| Income | Gender pay gap | American Community Survey, 5-year estimates | 2016-2020 |
| | Median household income* | Small Area Income and Poverty Estimates | 2020 |
| | Living wage | The Living Wage Calculator | 2021 |
| | Children eligible for free or reduced price lunch [‡] | National Center for Education Statistics | 2019-2020 |
| Family and Social Support | Residential segregation - Black/White | American Community Survey, 5-year estimates | 2016-2020 |
| | Residential segregation - non-White/White | American Community Survey, 5-year estimates | 2016-2020 |
| | Childcare cost burden | The Living Wage Calculator, Small Area Income and Poverty Estimates | 2021 & 2020 |
| | Childcare centers | Homeland Infrastructure Foundation-Level Data (HIFLD) | 2021 |
| Community Safety | Homicides* | National Center for Health Statistics - Mortality Files | 2014-2020 |
| | Suicides* | National Center for Health Statistics - Mortality Files | 2016-2020 |
| | Firearm fatalities* | National Center for Health Statistics - Mortality Files | 2016-2020 |
| | Juvenile arrests [‡] | Easy Access to State and County Juvenile Court Case Counts | 2019 |
| PHYSICAL ENVIRONMENT | | | |
| Housing and Transit | Traffic volume | EJSCREEN: Environmental Justice Screening and Mapping Tool | 2019 |
| | Homeownership | American Community Survey, 5-year estimates | 2016-2020 |
| | Severe housing cost burden | American Community Survey, 5-year estimates | 2016-2020 |
| | Broadband access | American Community Survey, 5-year estimates | 2016-2020 |

*Indicates subgroup data by race and ethnicity is available; *Not available in all states; [‡]2018 data for New Jersey.

See additional contextual demographic information and measures online at www.countyhealthrankings.org

Glossary of Terms, Technical Notes, and FAQs

Glossary of Terms

Health equity: Assurance of conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustice, and providing resources according to need.

Health inequity: Differences in health factors or outcomes that are systematic, avoidable, unnecessary, unfair, and unjust.

Health disparities: The numerical or statistical differences in health outcomes, such as mortality rate differences. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Technical Notes

- Figures 1 and 2 depict each county as a single, semi-transparent circle. Counties with very similar values are displayed as overlapping circles having greater color saturation. Similarly, circles representing states may be overlapping in Figure 4.
- The state and national values for childcare cost burden represent the median of counties within the state and nation, respectively.

FAQs

How does CHR&R select evidence-informed solutions?

Evidence-informed solutions are supported by robust studies or reflect recommendations made by experts. To learn more about our evidence analysis methods, visit [What Works for Health](#).

How does CHR&R rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. The aggregate z-scores are graphed next to the maps for health outcomes and health factors on pages 5 and 6 to show the distribution of the values that contribute to the rank. To see more detailed information on rank calculations please visit Our Methods section in **Explore Health Rankings** at: countyhealthrankings.org.

How did the 7% benchmark for childcare affordability originate?

The Department of Health and Human Services published a 2016 update to rules and regulations for the Child Care and Development Fund (CCDF) program, which helps cover childcare costs for children from low-income households. The updated rules established a federal benchmark for an enrolled family's childcare co-payments not to be considered affordable if costs exceed 7% of household income. The benchmark has since been applied outside of the context of the CCDF program to indicate that low- and middle-income families should not spend more than 7% of their income on childcare for it to be considered affordable.

How does CHR&R define county levels of urbanization?

We define levels of urbanization as: Rural (non-metropolitan counties with less than 50,000 people); Smaller Metro (counties within a metropolitan statistical area (MSA) with between 50,000 and 1 million people); Large Suburban Metro (non-central fringe counties within an MSA with more than 1 million people); Large Urban Metro (central urban core counties within an MSA with more than 1 million people).

How does CHR&R define racial and ethnic groups?

We recognize that "race" or "ethnicity" are social categories. Society may identify individuals based on their physical appearance or perceived cultural ancestry, as a way of characterizing individuals' value. These categories are not based on biology or genetics. A strong and growing body of empirical research provides support for the fact that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

We are bound by data collection and categorization of race and ethnicity according to the U.S. Census Bureau definitions, in adherence with the 1997 Office of Management and Budget standards. Our analyses also do not capture those reporting more than one race, of "some other race", or who do not report their race. This categorization can mask variation within racial and ethnic groups and can hide historical context that underlies health differences.

How does CHR&R define gender?

We recognize that while the terms "gender" and "sex" are often used interchangeably, they do not represent the same concept. Sex is generally assigned at birth based on observed anatomy, while gender is a social construct wherein certain tendencies or behaviors are assigned by society to labels of masculine or feminine. We know that neither gender nor sex are binary constructs and that people living intersectional identities (e.g., transgender women) experience compounding power differentials, which are not captured in a binary delineation between men and women.

Credits

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Talk to a Team Member:

Have questions about your data?
Need help finding an evidence-informed strategy?
Looking for more information on how to take action?

CHR&R team members are available to help you navigate the many resources we have available to support you on your journey to create healthy, equitable communities.

To contact us, please go to www.countyhealthrankings.org/contact-us. We're here to help!

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